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DEPARTMENT OF HEALTH AND HUMAN SERVICES. PRINTED: 03/15/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDENSUPPLIFRICITA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3). DATE SURVEY COMPLETED A. BUILDING_ 445190 D. WING NAME OF PROVIDER OR SUPPLIER 03/02/2017 STREET ADDRÉSS, CITY, STATE, ZIP CODE 200 BELLEBROOK RD. CAMBRIDGE HOUSE, THE BRISTQL, TN 37620 SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFIDIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISE IDENTIFYING INFORMATION) (XA) JD PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY) (X6) COMPLETION PREFIX TAG DA1 OATE FOOD INITIAL COMMENTS F 000 A recertification survey and investigation of complaints #40298 and #40649 were conducted at The Cambridge House on 2/16/17 - 3/2/17. Deliciencles were cited from the investigation of #40649 resulting in an Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury. harm, impairment or death to a resident) for the facility's failure to provide adequate supervision to prevent unsafe wandering and alopement (whon a resident leaves the premisos or a safe aroa without authorization), tallure to correct resident's Minimum Data Set (MDS) regarding their wandering, failure to provide Sufficient Nurso Slaffing to prevent clopement of residents, and for the Medical Director and Quality Assurance Committee's failure to identify safety hazards. An extended survey was conducted on 3/1/17 -3/2/17. The Administrator (NHA) was informed of the Immediate Jeopardy in her office on 3/1/17 at 1:25 PM. An Acceptable Allegation of Compliance (AOC), which removed the immediacy of the jeopardy, was received on 3/2/17 at 9:30 AM, and the corrective actions were validated onsite by SUlveyors on 3/2/17. The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. Substandard Quality of Care was effed under F-323 at a scope and severity level of "J". IABORATIONY DIRECTOR'S DIR PROVIDENIEUPPLIER REPRESENTATIVES SIGNATURE (XII) OAT E Any deficiency eleterment anding with an asteriak (*) denotes a delicionary which the institution may be excused from correcting providing it is determined that older safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 90 days

program participation.

following the date of survey whether or not a plan of correction is provided. For nursing homes, the whove findings and plane of correction are disclossible to days following the date these documents at add available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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AND PLAN OF CORRECT	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	USUPPLIERICLIA (X2) A ATION NUMBER: A DU	ILDINO NULTI	ruc construcțion	(X3) DA1	N LFLEI FD LE SOKAEA LE DANGEA
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Noncom	d From page 1 Iliance at F276; F280; F J F520 continues at a sc	323, F353.	7 000			
Severity of effectiver sustained	f a "D" level for monitori ess of conjective action ! compliance.	ing of the s to onsure				
SS=D PERSON			² 159	1. All current residents whose fun deposited with the facility will be g	ds are	
personal authorizat a fluctary safeguare funds of the specified of the spe	if a resident chooses turids with the facility, up ton of a resident, the facility of the resident's funds of the resident of the resident oposited win this section: Deposit of Funds. Personal funds in each operation of this section, the facility of th	pon written cility must act as and hotd, for the personal lith the facility, as lith the facility, as in personal lith the facility, as in personal lith the facility, as counts) that is operating est earned on in pooled fe accounting cility must do not uring account, each fund. ad by Medicaid; ents personal lith toring rate from any of and that credits and the credits and that credits are credits and that credits are credits and the credits are credits are credits are credits and the credits are cred		written notice that they will have access the funds 24 hrs a day 7 days a week This noticewill also be given upon admission. 2. The money will be kept in the Hasource Office in a metal locked from 8am to 5 pm Monday through A metal locked box will be left with charge nurse on the West Wing from 5 pm to 8am Mondaythrough residents and money in the account, a log from the residents to signout funds taken, and money will be checked daily be BOM Monday through Friday for accuracy. The BOM will replenish money box and log as needed.	uman box Frida the om ay and rho or The log	March 24, 2017

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	The facility must manot exceed \$50 in a Interest-bearing accounting (f)(10)(iii) Accounting excepted accounting accepted accounting personal funds enteresident's behalf. (B) The system must of resident funds will funds of any personal funds will funds of any person (C) The individual find available to after resident sand upon the facility each resident funds and upon (f)(10)(iv) Notice of comust notify each resident funds and upon person, specified the Act, and (B) That, if the amount person, the resident funds after resident funds after the facility failed to personal funds after the facility failed to personal funds after	aintain personal funds that do a noninterest bearing account, a noninterest bearing account, count, or pelly cash fund. It gand records. It establish and maintain a se full and complete and graccording to generally grinciples, of each resident's usted to the facility on the stability funds or with the other than another resident. It preclude any commingling the facility funds or with the other than another resident. It preclude any commingling the facility funds or with the other than another resident. It preclude any commingling the facility funds of the facility funds or with the other than another resident. It in the resident's account and the SSI resource limit for the section 1611(a)(3)(B) of the funds of the form one may lose eligibility for It is not met as evidenced ecord review and interview, revide uccess to resident regular business hours and	F 1	59			
	on weekends for 2 re	osidents (#23, #13) of 32					1

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	residents with personal residents with personal medical record revised mitted to the facilinctuding Depression Hypertension, Commy Myocardial Infarction Respiratory Faiture. Review of the residence of 9, indicating the recognitively impaired Medical record revised mitted to the facilinctuding Corebrova Diabetes Mellitus, History of Faiture, History in the resident's Resident #23's personal miterylew with Resident's Resident #13's personal faiture, Historylew with Resident Resident #13's personal faiture faiture, Interview with Resident Resident #13's personal faiture faiture, Historylew with Resident's Resident #13's personal faiture, Historylew with Resident Historylew with	conal funds accounts, ed: ew revented Resident #23 was lity on 6/23/16 with diagnoses on, Type 2 Diabetes Mellitus, munity Acquired Pneumonta, in, and Acute Hypoxemic ent's annual Minimum Data nent dated 12/27/16 revealed Mental Status (BIMS) score esident was moderately for dally decision making. ew revealed Resident #13 was lify on 6/5/13 with diagnoses scular Disease, Type 2 ypertension, Anxiety, Heart alling, Insomnia, Depression fection. ent's quarterly MDS 1/10/17, revealed a BIMS of the resident was daily decision making ent #23 on 2/27/17 at 12:14 Froom revealed money from conal funds account was not decision revealed money from onal funds account was not decision on all funds account was not decision was not available.	F	160			

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F 159	Continued From pa	usiness Office Manager on	F 159	F 278 Assessment Accuracy/Coordination/C ation	ertific	
F 278 SS≃J	Managers Office, or provide access to no regular business ho weekends. 483,20(g)-(j) ASSE ACCURACY/COOF	RDINATION/CERTIFIED	F 278	Corrective action(s) accomp for those residents found to	have	
	must accurately refl (h) Coordination A registered nurse reach assessment we participation of heat (i) Contification (1) A registered nurse the assessment is of	th professionals. The must sign and certify that completed. The completes a portion of the contract of the c	, i	Resident # 58's wandering a elopement risk assessment vupdated on January 24, 2017 resident's MDS was reviewed ascertain it was correctly confor the wandering and cloper section and the care plan upowith interventions to mitigate residents risk for wandering/elopement on Ma 2017.	vas 7; the ed to ded ment lated e the	
	who willfully and kno (i) Certifies a materic resident assessmen penalty of not more to assessment; or (ii) Causes another i	and Medicald, an individual		Resident # 10's wandering an elopement risk assessment wandered on March 1, 2017; the resident's MDS was corrected reflect the correct wandering elopement risk and the care pupdated to mitigate that risk of March 21, 2017.	as ne d to and ian	

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STATEMEN!	f of Deficiencies Of Correction	8: MEDICAID SERVICES (X1) PRÓVIDEIXSUPPLIEIXCLIA (DENTIFICATION NUMBER:	(A2) MULTIPLE A BUILDING	FROMSTRUCTION	OMB NO 0938-09 (XX) DATE SURVEY COMPLETED	
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F 278	subject to a civil me \$5,000 for each as (2) Clinical disagre- material and false: This REQUIREME by: Based on medical review of Incident// interviews, the facil itie wandering risk three residents revi- wandering and elop reviewed. The facil Resident #58 elopin an open fracture ("I way that bone frag- skin or a wound pe bone, the fracture is compound fracture surgical repair, and limmediate Jeopard provider's noncomp requirements of par likely to cause serio or death to a reside The Administrator (I Immediate Jeopard office. The thindings include Medical record reviewed admitted on 6/13/13 Dysphagia, Demont severe enough to in	coney penalty or not more than sessment. ement does not constitute a statement. NT Is not met as evidenced record review, observation, accident reports, and ty falled to accurately assess for two residents (#58, #10) of ewed with a known risk of rement, of 29 residents from the facility, sustaining from the facility, sustaining from the facility, sustaining from the facility, sustaining from the facility of the broken or called an "open" or ") In her right arm requiring placing Resident #58 in y (a situation in which the allance with one or more ticlpation has caused, or is tusting, harm, impairment, or). NHA) was informed of the y on 3/1/17 at 1:25 PM In her'		2. Identify other residents withe potential to be affected same deficient practice an corrective action taken: A. All residents have the potential be affected by this deficient practice. B. The DON ascertained that of current residents wander assessments were completed on a residents upon admission, quarterly and with a significate of the entire to ensure that the deficient practice does not reoccur: A. The licensed nurses were inserviced on February 21, by the Director of Nursing of facility's policy for accurate completion of the wandering elopement risk assessment.	by the d what ential to at 100% ering ed by will the 2017 on the	743 rch 24, 2017

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F278 Continued From page 6 Medical record review of an annual Minimum Data Set (MDS) assessment for Resident #58, dated 29/16, revealed a Drief Interview for Mental Status (BIMS) socio of 3, indicating Resident #58, had a severe cognitive impairment and include the provided in patient from the facility at 2:15 PM. Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the front dated 3/23/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the font down in the parking and elopement first was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the front down in the parking lot and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the front down in the parking lot and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the front down in the parking lot and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the front down in the parking lot and was confused. Medical record review of the MDS assessment the parking lot and was confused. Medical record review of the MDS assessment the parking lot and was confused. Medical record review of the MDS assessment for all residents were reviewed by the DON and/or designed and all residents identification of the resident's wandering patterns or triggers; interventions to minimize the resident was deviced by the parking lot and was confused. Medical record review of the MDS assessment for all residents were reviewed by the DON and/or designed and all residents solved to include identification of the resident's wandering parking the resident was a	j		-		250 BELLEBROOK RD	<u> U</u>	10212017
Medical record review of an annual Minimum Data Set (MDS) assessment for Resident #58, dated 20/16 fig. revealed a Drief Interview for Mental Status (BIMS) score of 3, indicating Resident #58 had a severe cognitive impairment. Further review revealed " Wandering - Processos & Frequency Behaviors not exhibited" (Per the MDS 3.0 Mental, wendering is the act of moving from place to place with or without a spacific course or known direction. The wandering resident may be oblivious to his or her physical or isafety needs.) Review of a facility Incident/Accident Report dated 2/22/16 revealed Resident #56 had eloped from the facility at 2-15 FVM. Resident #58 had eloped from the facility and was confused. Medical record review of the Wandering and elopement fisk. Review of a facility Incident/Accident Report dated 3/16/16 revealed Resident #56 had severe cognitive impairment and " Wandering for and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering for and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering for and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering for and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering for and was confused. Medical record review of the MDS assessment dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering for and the process of a facility incident/Accident Report dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering for and the process of a facility incident/Accident Report dated 4/25/16 revealed Resident #58 had severe cognitive impairment and " Wandering and elopement risk factors by March 1, 2017. The wandering and elopement	PREFIX	(ŒAC)! DEFICIENCY	MUST 46 PRECEDED BY FOUL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS.REFERENCED TO THE APPRO	ti n nc	(X+) CIDMPLETKIN DATI
from the facility at 4:10 PM. Resident #58 was		Medical record reviet Data Set (MDS) assistatus (BIMS) scool had a severe cognit review revealed " Frequency Behavior in the facility in dated 2/23/16 revealed 2/23/16 revealed 2/23/16 revealed 1/23/16 revealed 1/25/16 re	ew of an ennual Minimum sessment for Resident #58, led a Brief Interview for Mental of 3, indicating Resident #58 live impairment. Further Wandering - Procence & cas not exhibited" (Per the andering is the act of moving with or without a specific ection. The wandering livious to his or her physical or incident/Accident Report led Resident #58 had eloped 15 PM. Resident #58 was cility and was confused. In the Wandering and lent dated 2/23/16 revealed essessed as a wandering and helident/Accident Report ed Resident #58 had eloped 45 PM. Resident #58 had eloped wor the MDS assessment ed Resident #58 had severe and " Wandering - cyBehaviors not ecident/Accident Report ed Resident #58 had severe and " Wandering - cyBehaviors not		C. The MDSC and interdiscate team were in-serviced Mark 2017 on the need to proving accurate MDS by reviewing residents medical record, assessing the resident, interviewing the residents care givers and reviewing manual definitions before the MDS. D. The wandering and elopem risk assessments for all curresidents were reviewed by DON and/or designee and a residents identified as an elopement risk had their carplans revised by the interdisciplinary team to incidentification of the resident wandering patterns or trigger interventions to minimize the resident's wandering/elopement risk factors by Mark 1, 2017. The wandering and	meh 1, de an ng the direct the RAI coding ment rent the all e clude c's rs; e ment	

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	found outside that four and had internal duor and had internal feveraled one of the was Resident #58's Medical record roving assessment dated had severe cognitive "Wandering - Proposed for the was feel one of the was "exit acclaing" to revealed one of the was "exit acclaing" to revealed the resident wandering" Medical record reviews "Wandering - PresencyBehavior wandering - Presency wanderin	acility by the 500 hallway oxit mittent confusion. athic visit note dated 6/30/16, a chief complaints for the visit is "exit eeeking" bohaviors. ew of a quarterly MDS 7/8/16, revealed Resident #68 re impairment and sence & for not exhibited" ow of an Activity Progress revealed "She likes to go if frequently seeks ways to get affic visit note dated 7/19/16, chief complaints for the visit pehaviors. Continued roviow at "continues with the continues with the pairment and sonce & for a quarterly MDS 10/27/16, revealed Resident initive impairment and sonce & for a nanual MDS 10/2/14/16 revealed the resident impairment and sonce & for a minute mitter impairment and sonce & for a nanual mitter impairment and sonce & for a not exhibited"		reviewed by a licensed nurse all residents identified as an elopement risk will have the care plans revised by the interdisciplinary team to inclidentification of the resident wandering patterns or trigger interventions to minimize the resident's wandering/elopem behavior; and interventions to mitigate their individual elopement risk factors. Monitoring of corrective active ensure the deficient practice not reoccur: The Director of Nursing or designce will audit 3 recently completed MDS's each week 10 weeks and then monthly I months to ensure that each se of the MDS has been coded correctly. The results of this audit will reviewed by QAPI committee monthly to determine	ir lude 's rs; e nent to ion to will y c for for 3 section	March 24, 2011
<u> </u>	dated 1/17/17 revea	ncident/Accident Report led Resident #58 had eloped 00 PM. Resident #56 was	·	effectiveness of corrections n and need for further recommendations	nade	

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		445190	B WING			B3	/ 02/2 017 .
NAMEOF	RAUTTUS AC NICKON				STREET ADDRESS, CITY, STATE, JIP CODE	<u> </u>	
САМВВІІ ———	DGE HOUSE, THE				260 HELLEHROOK RD BRISTOL, TN 37620		
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F 278	Continued From pa	na 8	F 2	/R		•	. .
•	found outside the 4	00 hallway exit. Review of the	'~		1		
	resident was found	lying outside on her stamach beside her and had abrasions					\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	to her face and a sv	vollan wrist.					
	Medical record revi	ew of hospital records]
ļ.	revealed the resider	nt was transported to the					
`	an open right wrist (and had a surgical ropair for racture.					
	Medical record revide	ow of a 14 day MDS			•		
	assessment dated 2	2/6/17 revealed Resident #58					1
ĺ	had sovere cognitive "Wendering - Pre-	e impairment and sence &					
	FrequencyBehavl	ors not exhibited"	:				
:	Observation of Resi	ldent #88 on 2/16/17 at 10:00					
1	AM, revealed the re	sident in her wheelchair. aft hand to inove the					ŀ
]	wheelchair around t	he facility, with no end				_	
<u> </u>	destination.						
i	Interview with Socia	l Worker#1 on 2/16/17 at					-
	10:30 AM, in the cor	nference room, revealed					<u> </u> :
Ī	resident #58 did ex	hibit exit seeking behaviors rom the facility before"					!
ļ		-					
1	interview with Licens	sed Practical Nurse (LPN) #4 PM, In the conference room,]
i	revealed Resident#	58 "still wanders over the					
1	building"				-]
]	Observation of Resi	dent #58 on 2/16/17 between					
	10:00 AM and 1:30 (PM, revealed the resident			ļ		'
.	repeaterily propelling	the hallways of the facility. Is in the clining room for			1		[[
	lunch	and coming room to					
ŀ	Inferview with Social	Worker #1 on 2/17/17 at			!		
					J		1 1

FORM CMS-2587(02-99) Previous Versions Obsidate

Even; ID; 20Z711

Facility ID: TN8208

If continuation sheet Page 9 of 47

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		AND HUMAN SERVICES			•); (IM/15/2017 1 APPROVED
		& MEDICAID SERVICES	1				<u>. </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:			CONSTRUCTION	COS (X2) DV	TT SURVEY MPLETED
		445190	B, WING			03	/02/2017
NAME OF	PROVIDER OR SUPPLIER		'	`SY	REET ADDRESS, CITY, STATE, 7IP CODE	1 03	10212017
CAMBRII	DGE HOUSE, THE			251	0 DELLEBROOK RD RISTOL, TN 37620		
(X4) iD	SUMMARYSTA	VEMENT OF DEFICIENCIES	 		PROVIDER'S PLAN OF CONSECTION		- -
PREIDX TAG	(EACH DEHICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTH YING INFORMATION)	PREFIX TAG	c	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)	0.00	DATE DATE
F 278	MDS assessments	terence room, confirmed the for Resident #58 did not	F 2	78			
	Interview with the A Nursing (DON) on a conference room, of assessments dated 9/27/16, 12/14/16 a were inaccurate. O	te resident's Wandering status, administrator and Director of 2/17/17 at 9:55 AM, in the confirmed the MDS 12/0/16, 4/25/16, 7/8/16, and 2/6/17 for Resident #58 continued interview confirmed syed Wandering behaviors		:			
	admitted on 1/1/41	ew revealed Resident #10 was with diagnoses including ascular Disease, Demenlia, Disease.			,		
	assessment dated : #10's BIMS was 4 o	ew of the annual MDS 2/1/17, revealed (tesident out of a possible 15, showing pairment, and "Wandering - noyBehaviors not					
	Medical record revided 2/9/17 reveal elopement r/t (relate wandering"	ew of Resident #10's care planed "at risk for wandering and ed to] hx [history] of					
	PM, revealed the re around the facility in observation reveale	ident #10 on 2/16/17 at 1:30 sident was propelling frimself this wheelchair. Continued ditte would go from his room direpeat the process.					
	the 400 hallway oxil	#4 on 2/16/17 at 3:00 PM by door revealed Resident #10 is wheelchair to the front	[

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DEPART CENTRE	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/15/2017 APPROVED
STATEMENT	OF DEFICIENCIES F CONTRECTION	(X1) PROVIDENSUPPLIERICLIA IDENTIFICATION NUMBER:			C CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445190	B. WING			. 03/	02/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMBRII	DGE HOUSE, THE	, ,			260 BELLEBROOK RD DRISTOL, TN 37620		
(X4) ID FREHX FAG	(EACH DEFICIENCY	What de listededed by Laft What de listededed by Laft	ID PREH TAG		PREVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP OUT-DIERRY)	BE	jeki NOITJ.19400 BATAD
F 278	observation on 2/10 throughout the day, repeatedly wandere door, when his wife interview with Social 9:15 AM, in the condition of the condition of the condition of the condition of the limited and limit	to his room repeatedly when a facility. 6/17, at various times revealed Resident #10 and from his room, to the front was not present. al Worker #1 on 2/17/17 at ference room, confirmed the or Resident #10 did not be wandering behavior. diministrator and Director of 2/17/17 at 9:55 AM, in the confirmed the MDS 2/1/17 for Resident #10 was used interview confirmed een coded as non-wanderer, sering behaviors daily. pardy was effective from /17. An acceptable Allegation of removed the Immediacy of secived on 3/2/17, and vere validated through review invation, and staff interviews, ised the allegation of accility's in-service records to a Coordinators responsible the MDS's were in-serviced.	F	278	" "		
<u>. </u>		d of comprehension gained ce education conducted on					

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			,	PRINTER	0: 03/15/2017
CI-NTI-	RS FOR MEDICARE	& MEDICAID SERVICES				FORA	APPROVED 0. 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SIPPLIEH/CLIA IDENTIFICATION NUMBER:	A. BOILD	TIPI E MG_	CONSTRUCTION	(X9) LVC	NU ELED LC BRUAEA Gasag-0981
		445190	B. WING				
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	รท	REET ADDITUSS, CITY, STATE, ZIP CODE	<u>į ų</u> 3	/02/2017
CAMBR	(DGE HOUSE, THE		i	266	D BELLEBROOK RD RISTOL, TN 3/620		
(X4) ID PREFIX TAG	EAGH DEFICIENCY	TEMEN'I ÓF DÉPICIENCIES MUST BE PRIECEDED BY FULL CC IDENTIFYING INFORMATION)	ID PRETI		FROVIDER'S PLAN OF CORRECTIN (FACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPROX DEFICIENCY)	DE PRES	COMPLETION DAYS
F 280 SS=J	the MDS's for wand residents. 3. Reviewing the Management (Residents assessed at risk for developed on 3/1/17 the development of a Coprevent unsafe want. 4. Review of Residente assessment dated 2 corrected to show with the Compliance confusion of "D" for monitoring corrective actions at the Quality Assurant facility is required to Refer to F-323 "J" 483.10(e)(2)(i-iI,Iv,v) PARTICIPATE PLANTS	to regarding correctly coding cring behaviors of the MDS assessment of all sites, #10, and #68) wandering and elopement of all sites, #10, and #68) wandering and elopement or corrected MDS to aid in the comprehensive Care Plan to dering and elopement. Item #58's 30 day MDS #220/17 revealed it had been andering behaviors occurred the effectiveness of the effectiveness of elevaluation of monitoring by the (OA) Committee. The submit a plan of correction. (3),483.21(b)(2) RIGHT TO INING CARE-REVISE CP	F 20	30	F 280 Right to Participate Planning Care – Revise Cl Corrective action(s) accomp		
-n	and implementation plan of care, including (i) The right to particl including the right to be included in the planet meetings an revisions to the person	pate in the planning process, identify individuals or roles to applications process, the right to			for those residents found to been affected by the alleged deficient practice: Resident # 58 was transferre the hospital post incident on January 17, 2017. Upon his return to the facility on Janu	d to	

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If continuation short Page 13 of 47

	THAND HUMAN SERVICES NELS MILDICAID SERVICES			RIN (FD= 03/15/201) FORM APPROVE
STATISMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CY2) AND YELL	CONSTRUCTION	MB NO. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X0) DATE SURVEY COMPLETED
	445190	B. WING		(12/00/2047
NAME OF PROVIDER OR SUPPL	IFR	<u> </u>	REST ADDRESS, OTY, STATE, 212 CODE	03/02/2017
Cambridge House, The	i		IO BELLEBROOK RD	
		C	RISTOL, TN 37620	
PRECIX (FACH DEFICIA	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY INTEL OR LISO IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD OROSS-REFERENCED TO THE APPROP DEFICIENCY)	រ បោះ 📗 ខ្លួនរថ្ងៃ 🖟 ពេក្យា
expected goals amount, frequer other factors religion of care. (iv) The right to included in the plan to sign after of care. (c) (d) The lacility right to participate to	participate in establishing the and outcomes of care, the type, and outcomes of care, the type, and any ated to the effectiveness of the roccive the survices and/or items than of care. See the care plan, including the algoriticant changes to the plan of the plan are the plan including the resident of the plan are in his or her treatment and a resident in this right. The		24, 2017, a new wandering an elopement assessment was completed and his/her care pla updated to identify the resider wandering/elopement triggers interventions to mitigate those triggers. The facility was in the process of installing a wanderguard system at the time of the incident and at this time exit doors are alarmed as well the courtyard door. Identify other residents who have a second as the courty and door.	nt's and ne all as
(i) Facilifate the resident represe	inclusion of the resident and/or ntalive.		the potential to be affected by same deficient practice and we corrective action taken:	
strengths and no (iii) Incorporate (resesment of the resident's reds, the resident's personal and ces in developing gnals of care.		All residents have the potential to be affected by this deficient practice.	3
	isive care plan must be- thin 7 days after completion of	3.	Measures/systematic changes in place to ensure that the deficient practice does not reoccur: The facility staff were in-serv	
(ii) Prepared by a fincludes but is not one of the case of the cas			by the facility DON / Administrator on the followin 2/17/17 through 2/20/17 durin face to face training/lecture - sessions (and for those not	

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DEPAR CENTE	TMENT OF HEALTH	IAND HUMAN SERVICES			FORM	. 03/15/2017 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDERGUPPLIFRICHA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	OMSTRUCTION	CYN EIMS TAG (CX)	<u>- 0938-0391</u> E AUNVRY PUTTED
<u>_</u>		445180	D. WING			
NAME OF I	ROVIDER OR SUPPLIER		smi	LT ADDRESS, CITY, STATE, ZIP CODE	<u> 1 03/</u>	02/2017
CAMBRI	DGE HOUSE, THE	<u> </u>	250 (BELLEBROOK RD RTOL, 1N 37620		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY MULL SCIDENTILYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GROUND GROUND SHOULD CROSS-REFFERENCED TO THE APPROPRIEFICIENCY)	1 1472	COMPLETION DATE
	resident. (C) A nurse aide will resident. (D) A member of form the resident and the resident and the An explanation must medical record if the and their resident renot practicable for the resident's care plant. (F) Other appropriate disciplines as determor as requested by the comprehensive and comprehensive and	Inysician. The with responsibility for the the responsibility for the the responsibility for the the and nutrition services staff. The section of the resident's representative(s), at be included in a resident's a participation of the resident spresentative is determined the development of the the staff or professionals in ninced by the resident's needs the resident. The section of the interdisciplinary essment, including both the resident.	iv.	attending either of these set they were in serviced in the manner before their next scheduled shift) Dementia: types of dement causes and behavioral symplement behaviors and identification of resident sporting elopement behaviors Elopement risk factors Wandering risk assessment completed on admission, quarterly and with any sign change in condition.	ssions same ia, otoms ecific d	
	by: Based on review of reviow, observation, Incident/Anddent rej facility failed to revisi	ports and interviews, the the care plan ofter each	vii.	MAR. Each alarmed exit door is to for functionality daily by the Maintenance Director or his designee and on weekends to	sted	
	clopement attempt for residents reviewed for 29 residents revier resulted in Resident sustaining an open (" way that bone fragman skin or a wound pond	or 1 Resident (#58) of 3 or wandering and elopement, wod. The facility's failure #58 eloping from the facility. "If the bone breaks in such a ents slick out through the etrates down to the broken	viii.	day shift supervisor. Developing and implementi effective interdisciplinary pl care for the resident at risk i wandering / elopement	ng an lan of	

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DEPART	MENT OF MEALTH	AND HUMAN SERVICES 8 MEDICAID SERVICES				PRINTED FORM): 03/15/2017 1APPKOVED
STATEMENT	OF DEFICIENCIES F CORRECTION	COL) TABOARDERS THE ACTIVE STREET STR			CONSTRUCTION	OMB NO. 0938-039 (X3) DATE BURVEY COMPLETED	
NAME OF F	ROVIDER OR SUPPLIER	485190	ם. יאואס			03)	/02/ <u>20</u> 47
	OGE HOUSE, THE			26	D BELLEBROOK RD RISTOL, TN 37620		
(X4) ID PREFEK I/\C	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUSY HE PRECEDED BY FULL SC 'DENTIEYING INFORMATION)	PREFI; TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRIL DEFICIENCY)	It things	COMPLETION (X2)
	sompound fracting surgical repair, plant immediate Jeopard providers moneomic requirements of particular mediate Jeopard of death to a reside The Administrator (Immediate Jeopard office. The findings include Review of the facility is revised in a provide preventative provide preventative for the surgicy of the developed and implitude to the facility. Upon require should, Implement is identified as a colopement. Reside the facility. Upon require should, Implementation with elopement. Medical record revise admitted on 6/13/13 Dysphagia, Dement of daily living), Hype Cancer, Osteoporos Review of a Brief Interview	a called an "open" or "I fracture to her arm requiring ing Resident #58 in y (a situation in which the illanse with one or more licipation has caused, or is us injury, harm, impairment, it it. NHA) was informed of the y on 3/1/17 at 1:25 PM in her add: "S policy "Wandering and 8/4/03; revealed "Purpose: guidelines regarding re of the resident with the and/or elope The facility will a inferventions as necessary resident Acare plan will be embrited for each resident at risk for wandering and/or in the facility, the charge ment interventions to prevent update the resident's care precautions" We revealed Rosident #58 was the risk of mental ability terfere with normal activities at (a loss of mental ability terfere with normal activities at and Depression, cryiew for Mental Status	F 2		ix. The Cambridge House's and procedure for Wande Blopement/ Managing Elinchuding how to respond door alarm or missing rest. For the Resident observed attempting to leave the procedure attempting to leave the procedure attempting to leave the procedure attempting to leave premises to the charge nu soon as possible. 2. If an employee observes a leaving the premises, he/s should: a. Approach the resident cal walk with the resident. He side-by-side conversation verbal re-direction and disas you walk. b. Avoid confrontation and refrom overpowering the resident resists assist return and is in imminent contact guidance may be a contact guidance may be a contact guidance from oil members in the immediate vicinity, if necessary. c. Instruct another staff meminform the charge nurse the resident has left the premisers.	ring and opement to a sident: d remises: any ve the resident she mly and ave a and use struction refrain sident. danger, dilized, her staff.	March 24, 2017
	Cours) delibo Sigilio	revealed a score of 3,		<u> </u>		}	1

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EDICAIO SERVICES				FORM:	03/16/2017 APPROVED		
PROVIDENSUPPLIFRICLIA DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	TELED F SDBAEA D3204031		
445180	B. WING			03/0	12/2017		
	ł						
NT OF DEFICIENCIES FOR PREIZEDED DY PULL NTIPYING IMPORMATION)	90 PREFIX TAG		(FACH CORRECTIVE ACTION SHOULD	RF	OSSI COMPLETION DATE		
had a severe cognitive Review of Resident an Intervention for at "Problem/NeedAt tisk for wandering d to hx (history) of very) 15 min's [minutes]mental health eval aw meds [modications]" ent/Accident Report Resident #58 had eloped M. Resident #58 was allway door. Review of aled "door atarm out the 500 hall door to g, brought back in by ant[CNA] #2] and vas alent but confused problem onset date ring and elopement" added for 2/23/16 interventions in place," ons that were already on 16. The care plan was interventions to prevent dent/Accident Report Resident #58 had cloped M. Resident #58 was oors in the parking lot. eport revealed " door - [and] made her formal by pursion cloff the	F 2		3. Upon return to the facility, the charge nurse will: a. Examine the resident for injust. b. Implement interventions to prevent further elopement, to the "Wandering and Elop Development of the Care Plet. Notify the resident's attending physician of the incident. d. Notify the Director of Nursities. Notify the resident's respons party/legal representative of incident. f. Complete and file an incident report. g. Make appropriate notations resident's medical record and update the resident's plan of to include elopement precauth. Document the incident on the hour report. ki. For the Resident discovered missing from the facility. 1. All personnel are to report and resident suspected of being missing to the charge nurse a soon as possible. 2. If an employee discovers that resident is missing from the	(Reference to coment lan) ing sible the difference tions. It is the land of th			
THE PROPERTY OF THE PROPERTY O	A45188 A45188 A45188 AF OF DEPICIONCIES OF PRECEDED BY PULL NITHYING IMFORMATION) AND SHOCK OF COUNTY AND SHOULT OF COUNTY AND SHOCK OF COUNTY AND SHOULT OF COUN	A SUITE AT A SUITE AND PENTIFICATION NUMBER: 4451811 B. WING A 451811 B. WING A 501101 A 451811 B. WING A 501101 A 501101 A 501101 A 501101 A 501101 A 601101 A 701101 A 70110	PROVIDENSIDENCIA A SUILDING BE WISS THE PRECERPED BY PULL INTERNO INFORMATION) F 280 F 280	### Addident Report Resident #58 had cloped M. Resident #58 had cloped minerownions on place" #### Addident Report Resident by the resident for injunction on the soon had was interventions to provent further clopement. The solid minerownion on the soon had deependent. The solid minerownion on the soon had deependent. The solid minerownion on the soon had deependent. The solid minerownion on place The solid minerownion of the solid minerownion on the soon half door of the solid minerownion of the solid minerownion of the solid minerownion. The solid minerownion of the solid minerownion. The solid minerownion of the solid minerownion	A45188 CX: MULTIPLE CONSTRUCTION 445188 E. WING STREET ADDRESS, CITY, STATE, ZIP CODE 256 BELLEBROOK RD BRISTOL, TN 37620 PREPIX TAO PROVIDENTS PLAN OF CORRECTION SHOULD BE GRACH		

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סטיאתי	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED	00/15/2017
CINIE	RS FOR MEDICARE	& MEDICAID SERVICES		•	FORM	RAPPROVED
WIN IS CINV	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDEN/SUPPLIER/OUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	ראלו (מאלו	0938-0391 TE SURVEY MILITIED
- 		445190	D. WING		02	Muma
NVWE DE	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 7IP CODE.		/02/2017
CAMBRI	DGE HOUSE, THE			ZGO BULLEBROOK HO BRISTOL, 'IN 37620		
(X4) ID PREFIX YAG	(EACH DĽĽSČIENG)	TEMENT OF DEFICIENCIES MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX 1/AG	PROVIDER'S PLAN OF CONNECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLY DEFICIENCY)	110.00	COMPLETION DATE
	Review of the care revealed the interventions" No the resident from an implemented on the Review of a facility of dated 6/10/16 reveation the facility of dated 6/10/16 reveation the facility of dated 6/10/16 report reveation to utside 500 had accident report reveating from the facility of dated for 6/10/16 elabove interventions. Review of the care padded for 6/10/16 elabove interventions. Review of the facility dated 1/1//1/ reveating the facility dated 1/1//1/ reveating the facility dated 1/1//1/ reveating the facility at 9: found outside the 40 accident report reveation the facility at 9: found outside, at botto the facility dated 1/1//1/ reveating outside, at botto for the facility dated 1/1//1/ reveating outside, at botto for the facility dated 1/1//1/ reveating outside, at botto for the facility dated 1/1//1/ reveating outside. The facility dated 1/1//1/ reveating outside the 40 for facility dated 1/1//1/ reveating for the facility dated 1/1//1// reveating for the facility dated 1/1//1// reveating for the facility dated 1/1//1// reveat	into building" Resident was and had no Injuries". plan problem dated 2/9/16 ention added for 3/16/16 ention added #	F 20	 a. Determine if the resident an authorized leave or parnot; b. Notify the charge nurse immediately. He/she will direct a search of the build and premises including all of the building. If not loc 3. The charge nurse will direct search of the facility ground using the "Search Grid for Elopement" – facility speciandoors and outdoors of the facility. 4. The charge nurse will take a resident headcount. 5. Notify the administrator and director of nursing as soon possible and within 30 min 6. The Director of Nursing, or designee, will coordinate to following search procedure. a. Divide the local area around facility and assign a stall to search each area and repart the coordinator when the secondlete. 	then ding(s) l areas ated; t a nds cific for e as autes. he e: nd the person port to	

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DEPART	IMENT OF HEALTH	AND HUMAN SERVICES			F	RINTED:	03/15/2017
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDEN/SUPPLIER/GLIA IDEN HEICAYION NUMBER:			CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PI ETÇO
<u> </u>		445190	B. WING			0.24	00004=
NAME OF I	ROVIDER OR SHEPLIER		` - -	73	REET ADDRESS, CITY, STATE, 294 CODE	usn	02/2017
CAMBRI	DGE HOUSE, THE		1	25	0 BELLEDROOK RD		
:	·		L	H	KISTOL, TN 37620		
(X4) ID PREFIX . TAG	(EACH DEFICIENCY	ac iĎEkzikarka ingorwylion) NNSL ŘEJŠKĘCEDED NA POTT LWOUL OŁ DELICIEKCIES	ID PREFIX TAG	`	PROVIDER'S PLAN OF CORRECTION SHOULD GROSS-REFERENCED TO THE APPROXIMATION SHOULD CROSS-REFERENCED TO THE APPROXIMATION OF THE APPROXIM	0.9E	(XX) COMPLETION DATE
F 280	open fracture to the Review of the care	right arm. plan dated 2/3/17 revealed "At	F 24		 Determine the areas/sites in community with which the resident may have familian (stores, restaurants, or hom 	itv.	·
	tisk for wandering a the intervention for "continue above it same interventions	and elopement" and revealed the elopement was nterventions" referring to the since 2/9/16. The care plan	1	- 	Assign necessary staff to se these areas.	earch	
	the resident from ex elopement on 1/17/	n new Interventions to prevent dling the facility after the 17 which resulted in injuries.			7. If the resident is not located one hour, notification shou include, but is not limited to	ıld	
	AM, revealed the re	ident #58 on 2/16/17 at 10:00 sident in her wheelchalr, eft hand to move the he fecility.	-		 a. Responsible Party b. Resident's physician c. Local police d. Hospitals, emergency room 	18	
-	10:30 AM in the cor Resident #58 did ex and "had eloped fi	ll Workor#1 on 2/16/17 at liference room, revealed falbit exit seeking behaviors, rom the facility before"			8. Upon return to the facility, the charge nurse should:a. Examine the resident for into the confidence of the charge of the	he Juries.	. '
<u>:</u>	2/16/17 at 12:30 PN confirmed the facility with new intervention	tor of Nursing (DON) on I in the conference room, I failed to revise the care plan Ins to prevent further In olopement attempt.			prevent further elopement. to the "Wandering and Elop Development of the Care P c. Notify the search team men	(Refer	
	PM, revealed the re- using her feet and to whoelchair around to	he facility.		(the administrator and the di of nursing that the resident been returned to the facility 1. Notify the resident's attendi	rector has	
	9:45 PM in the confo facility failed to revis interventions to prev	dministrator on 2/16/17 at erence room, confirmed the ere the care plan with new vent further elopement.			physician of the incident. Notify the resident's respon party/legal representative of incident.	fthe	
·		pardy was effective from The facility presented an		Í	Complete and file an incide.	nt	

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		AND HUMAN SERVICES		12	RINTEO, 03/16/201 FORMAPPROVE		
		& MEDICAID SERVICES			MB NO. 0938-039		
	OF DEFIGIENCIES OF CONRECTION	(XI) PROVIDEN/SUPPLIERICUA IDENTIFICATION NUMBER:	(X2) MULTIPI A. GUICDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445190	ก. พมช		03/02/2017		
NVME OF F	PROVIDEN OR SUPPLIER		Š	TIREET ADDRESS, OITY, STATE, ZIP CODE	<u></u>	٠.	
CAMBRI	DGE HOUSE, THE			BELLEDROOK RD BRISTOL, TN 37620			
(XV) ID PREFIX TAO	(EACH DEFICIENC)	LEMENT OF DEFICIENCIES MUST HE PRECEDED BY FULL SC DENTIFYING INCORMATION)	PREFIX 1'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL!) CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED FOR THE APPR	MOUTCHANDS SEC		
F 200	implementation of the staff were in-sepolicies: Wandering, Unsafeth Wandering, Unsafeth Wandering, Unsafeth Wandering, Unsafeth With staff to include Registered Nurses, Licensed Practical Assistants, 3 House Dietary, 2 Modical I Director, 2 Busines Receptionist for a towas to deformine it gained through in-stacility's policies, chellegoment policy, in Wandering, Unsafeth these policies had consider wander guard three residents were allowed their wander guard three residents were successful three residents we	on of Compliance and the AOC was validated by add by the surveyors to validate received on the following persent Resident release beginning on 3/2/17 the Administrator, 8 Director of Nursing Steeping and Laundry staff, 4 Record staff, 1 Maintenance of Solice staff, 2 Rehab staff, 1 had of 60 employees. This is level of comprehension ervice education regarding the ranges to the Wandering and replamentation of the policy. Resident, and the effect on staffing levels. Residents #58, #10, and #68 M revealed them all to have bracelets in place. These is assessed as wanderers. Ical record and care plans for, and #68, on 3/2/17 at 2:30 are plans had been updated Continued review revealed for is displaying other high risk the placed on 1:1 monitoring shalledthe Director of icd " Continued review of "2/23/17 Wanderguard check Wanderguard q	F 280	g. Make appropriate notations resident's medical record an update the resident's care pleasant the incident on the lour report. i. The Administrator/designee ensure a completed report is forwarded to Risk Managem and all required state reporting agencies. All employees were tested on their retention of the information presented at these in-service sessions by March 2, 2017. It comployee did not score 80% higher they were retrained on above information. This inservice is also included in the hire orientation process and reviewed annually with all employees. F280 Continued (See affached page	will ment ng narch the new	11	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P	RINTED:	03/15/2017
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES				MB NO	APPROVED 0938-0391
AND PLAN (OF DEFICE NOT S F CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:	(X2) MU! A. BU!(1)		L CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		445190	B. WING		· · · · · · · · · · · · · · · · · · ·	031	03/2047
NAME OF I	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	1 691	02/2017
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				В	RISTOL, TN 37620	•	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	סו		PROVIDER'S PLAN OF CORRECTION	<u> </u>	(25)
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r: 200	00-				Elopement drills were held on		<u> </u>
F 280	Continued From pa		F 2	80	February 17, 2017 for the 7am	to	1 1
	acceptable Allegation	on of Compliance and			7pm shift and on February 18,]
	interviews conducts	he AOC was validated by		- 1	2017 for the 7pm to 7am shift.	Δn]]
	the staff were in-ser	d by the surveyors to validate viced on the following			elopement drill will be held by		
	policies:	wided our tile tollowing			Administrator or his designee of		۱۰ [
	Wandering and Elo					31 1	1
Ì	Wandering, Unsafe	Resident		- 1	each shift twice a year with an		
	Conducted inter		•		assessment of the staff	ļ	·
	with staff to include	rviews beginning on 3/2/17			performance and adherence to]	
	Registered Nurses	Director of Nursing, 6			facility policy during the drill	. 1	ı
	Licensed Practical I	Nurses, 20 Certifled Nursing		Ì	presented to the QAPI committee	ee	
	Assistants, 3 House	keeping and I aundovistaff A			for review and further	}	: · · · · · · · · · · · · · · · · · · ·
	Dietary, 2 Medical F	lecord staff. 1 Maintenance			recommendations		1
	Director, 2 Business	Office staff 2 Rehab staff 1		ľ		1	
	was to determine the	ital of 50 employees. This			The DON ascertained that 1009	%	
	dained through in-ea	e level of comprehension ervice education regarding the			of current residents wandering	·	1
	facility's policies, chi	anges to the Wandering and		- 1	assessments were completed by	,	[
	Elopement policy, in	oplementation of the noticy		-	February 19, 2017. The DON v		1
	wandering, Unsafe	Resident, and the effect		i	ascertain that the wandering	""	· ·
	these policies had o	n staffing levels.			assessment is completed on all		. !
ĺ	7 Obcenselles et 1	Desire was not		-	residents upon admission,	ŀ	i
}	on 3/2/17 at 5:00 Bt	Residents #58, #10, and #68 A revealed them all to have			condents upon admission,		Ī
ľ	their wander quark i	pracelets in place. These			quarterly and with a significant		
	three residents were	e assessed as wanderers.			change.	ļ	ĺ
	3 Review of made	cal report and acceptance	•		The wandering and elopement		•
	Residents #58, #10	cal record and care plans for and #68, on 3/2/17 at 2:30		1	risk assessments for all current	1	1
	PM revealed their ca	are plans had been updated			residents were reviewed by the		
1	to reflect changes. (Continued review revealed 1			DON and/or designee and all		
	"Itexit seeking o	r is displaying other high risk		-	residents identified as an	- 1	
1	neusviorss/he Will	be placed on 1:1 monitoring [· · · · · · · · · · · · · · ·		1
	until exit seekings	batedthe Director of		Į	clopement risk had their care]
ļ	rvursing will be notifi	ed" Continued review of			plans revised by the	.	- 1
	Diaced on Resident	2/23/17 Wanderguard check Wanderguard q			interdisciplinary team to includ	.e	
	[every] shift by door	accuracy "		- 1	identification of the resident's]	
7011010	7/11/10				wandering patterns or triggers;		

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/15/2017 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			CONSTRUCTION	On	COMPLETED COMPLETED	
		445190	B WING				02/	<u>0</u> 2/2017
NAME OF F	ROVIDER OR SUPPLIER		<u>- </u>	ST	REET ADDRESS, CITY, STATE, ZIP CO	ODE	03/	0212017
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07 (() D) ()	30E 110,00E, 111E		- 1	BR	RISTOL, TN 37620		•	
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F 280	implementation of the interviews conducted the staff were in-set policies: Wandering and Eloy Wandering, Unsafe 1. Conducted interview with staff to include Registered Nurses, Licensed Practical It Assistants, 3 House Dietary, 2 Medical Foirector, 2 Business Receptionist for a towas to determine the gained through in-sefacility's policies, che Elopement policy, it Wandering, Unsafe these policies had consider wander guard if three residents were assidents #58, #10. PM revealed their control of the considering will be notificare plan revealed the considering will be notificare plan revealed.	on of Compliance and the AOC was validated by the surveyors to validate reviced on the following persent Resident Tryiews beginning on 3/2/17 the Administrator, 8 Director of Nursing, 6 Nurses, 20 Certified Nursing excepting and Laundry staff, 4 Record staff, 1 Maintenance of Office staff 2 Rehab staff, 1 otal of 50 employees. This is level of comprehension ervice education regarding the anges to the Wandering and implementation of the policy Resident, and the effect on staffing levels. Residents #58, #10, and #68 or excelets in place. These is assessed as wanderers. Cal record and care plans for, and #68, on 3/2/17 at 2:30 are plans had been updated Continued review revealed or is displaying other high risk I be placed on 1:1 monitoring abatedthe Director of ited" Continued review of2/23/17 Wanderguardcheck Wanderguard q accuracy"	F 24		interventions to minimize resident's wandering/ele behavior and intervention mitigate their individual clopement risk factors belopement risk factors belopement risk assessment residents will continue the reviewed by a licensed residents will continue the reviewed by a licensed residents identified a clopement risk have their plans revised by the interdisciplinary team to identification of the residentification of the residentification of the residentification stominimize resident's wandering/ele behavior; and intervention mitigate their individual elopement risk factors. For residents identified a wandering/elopement the following protective mentaken: Photo identification will in a private area of the nestations and at the front was completed on Februa 2017. The resident will wear a band with the resident's	opemer ons to learn so be nurse as an ir care of included dent's riggers; ze the opemer ons to learn so be placed as ures a learn so learn	all and le for arc ced his	and the first
	/ and signed sectioning	Event ID: 2UZT11		Fácilil	y ID: TN8206 If co	oidsunitne	n sheet P	age 19 of 47

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	PROVIDER OR SUPPLIER DGE HOUSE, THE			25	RFF1 AUDRESS, CITY, STATE, ZIP CODE 0 BELLEGROOK RD RISTOL, 'TN 37620	. 1 03/	02/2017
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F 280	acceptable Allegatic implementation of to interviews conducted the staff were in-set policies: Wandering and Elo Wandering, Unsafe 1. Conducted interviews and Elo Wandering, Unsafe 1. Conducted interview in the staff to include Registered Nurses, Licensed Practical Massistants, 3 House Dietary, 2 Medical Forector, 2 Business Receptionist for a towas to determine the gained through in-set facility's policies, che Elopement policy, in Wandering, Unsafe these policies had on 3/2/17 at 2:00 PM their wander guard if three residents were 3. Review of medical Residents #58, #10, PM revealed their cato reflect changes. "ifexit seeking on behaviorss/he will until exit seekinga Nursing will be notificate plan revealed."	on of Compliance and the AOC was validated by the surveyors to validate rviced on the following persent Resident Triews beginning on 3/2/17 the Administrator, 8 Director of Nursing, 6 Nurses, 20 Certifled Nursing excepting and Laundry staff, 4 Record staff, 1 Maintenance is Office staff 2 Rehab staff, 1 otal of 50 employees. This is elevel of comprehension envice education regarding the anges to the Wandering and implementation of the policy Resident, and the effect in staffing levels. Residents #58, #10, and #68 of revealed them all to have bracelets in place. These is assessed as wanderers. Cal record and care plans for and #68, on 3/2/17 at 2:30 are plans had been updated Continued review revealed in is displaying other high risk to be placed on 1:1 monitoring abatedthe Director of ed" Continued review of2/23/17 Wanderguardcheck wanderg	F 28		lacility address and phone clearly marked. This was completed on February 19 The resident will be wear a wanderguard sensor. Come on February 21, 2017. The resident's care plan wandering wandering elopement behavior and cannot be and interventions assessed to have a high elopement or other behavior. The plan of identifies triggers wandering/elopement behavior. The plan of identifies triggers wandering/elopement behavior. The plan of identifies triggers wandering/elopement behavior and interventions have implemented to minimize triggers as of March 1, 20 resident is actively exit se is displaying other his behavior and cannot be redirected s/he will be plant to be a possible of the plant of the pl	, 2017. a pleted fill be sto avior; erns or arch 1, erns of care risk of unsafe of care for ehaviors e been to those of risk e easily laced on the exit of the ex	

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	acceptable Allegatic implementation of the interviews conducted the staff were in-serpolicies: Wandering and Elop Wandering, Unsafe 1. Conducted interwith staff to include Registered Nurses, Licensed Practical Nassistants, 3 House Dietary, 2 Medical Rolletary, 2 Medical Receptionist for a towas to determine the gained through in-sefecility's policies, challetary in Wandering, Unsafe these policies had on 3/2/17 at 2:00 Photheir wander guard in three residents were at the residents #58, #10, PM revealed their catoreflect changes. ("ifexit seeking on behaviorss/he will until exit seekinga Nursing will be notificare plan revealed"	on of Compliance and the AOC was validated by and by the surveyors to validate reviced on the following openent. Resident Views beginning on 3/2/17 the Administrator, 8 Director of Nursing, 6 Nurses, 20 Certified Nursing Reeping and Laundry staff, 4 Record staff, 1 Maintenance of Office staff 2 Rehab staff, 1 fall of 50 employees. This relevel of comprehension envice education regarding the anges to the Wandering and applementation of the policy—Resident, and the effect on staffing levels. Residents #58, #10, and #68 or accelets in place. These reassessed as wanderers. The plans had been updated continued review revealed or is displaying other high risk be placed on 1:1 monitoring batedthe Director of ed" Continued review of2/23/17 Wanderguard check Wanderguard check Wanderguardcheck wanderguard	F 28		notified immediately and s/ho assess staffing needs of facility, assigning staff complete the 1:1 monitoring calling in additional staff indicated. This monitoring the resident's response will documented in the nurse's by the charge nurse for each the resident is placed on monitoring. Monitoring of corrective actions the deficient practice vanot reoccur: The Director of Nursing and/her designee has completed a 100% audit of the resident population to ascertain their wandering & elopement risk assessment had been completed according to facility policy by Pebruary 19, 2017. The Director of Nursing and/or designee has ascertained that those resident identified as at risk for elopemare wearing a wanderguard sensor, that each resident's se is checked for functionality exhift and documented on the medication administration recommends.	the to to and f as and l be notes shift l:1 on to vill or ed tor as is nent nsor very	

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	acceptable Allegatic implementation of the interviews conducted the staff were in-serpolicies: Wandering and Eloy Wandering, Unsafe 1. Conducted interviews to include Registered Nurses, Licensed Practical Massistants, 3 House Dietary, 2 Medical Find Director, 2 Business Receptionist for a towas to determine the gained through in-seriality's policies, challengement-policy, in Wandering, Unsafe these policies had on 3/2/17 at 2:00 Pheric wander guard their wander guard three residents were as a Review of medical Residents #58, #10, PM revealed their cato reflect changes. ("ifexit seeking on behaviorss/he will until exit seekinga Nursing will be notificare plan revealed"	on of Compliance and the AOC was validated by the surveyors to validate reviced on the following persent Resident resident, and the effect resident, and the effect resident, and the effect resident #58, #10, and #68 revealed them all to have residents #58, #10, and #68 revealed them all to have reacelets in place. These reassessed as wanderers. residents resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident	F 28	This audit will be complete weekly for four weeks an monthly for two months. results of the audit will be presented to the QAPI confor their review and furth recommendations. 5. Date of Correction: March 2017	d then The : mmittee er	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/15/2017 APPROVED	
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F 280	Continued From po	ge 19	ř ř2	во			
F 323 SS=J	of "D" for intentions of the Quality Assurant actions of the Quality Assurant actions of the Quality is required to Refer to F-323 "J" 483,25(d)(1)(2)(n)(HAZARDS/SUPER (d) Accidents. The facility must enform accident in and assistance deviant assistance deviant ensure correct maintenance of bed to the following element of the following element of the resident or resk the resident or resk informed consent p (3) Ensure that the appropriate for the appropriate for the	vironment remains as free rds as is possible; and sceives adequale specialist, accidents, leading a side or side rall is used installation, use, and traits, including but not limited nents. I to installation. I and benefits of bed ralls with lent representative and obtain	. F3	F 323 Free of Acciden Hazards/Supervision/ 23 1. Corrective action(s) accident those residents foun been affected by the alledeficient practice: Resident # 58 was trans the hospital post incident January 17, 2017. Upon return to the facility on . 24, 2017, a new wandering elopement assessment we completed and his/her campdated to identify the rewandering/clopement triinterventions to mitigate triggers. The facility was process of installing a wanderguard system at the of the incident and at this exit doors are alarmed as the courtyard door	Devices complished to have eged ferred to at on a his/her January ing and was are plan exident's egers and those in the		

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E 743			[2. Identify other residents w	ho have	·
F 323			F 3:	23	the potential to be affected		
	regiew review of far	facility policy, medical record cility incident/Accident			same deficient practice an	~	
	Reportsobservatio	his and interview, the facility			corrective action taken:	** ********	}
	failed to provide add	aduate supervision to prevent and elopement from the facility		٠	oragonia delicut (alcul-		
-	-for 1 Resident (#58)	no elopainent from me radility :) of 3 residents reviewed for			All residents have the	ا ر ع	
,	elopement risk, of 2	9 residents reviewed. The			potential to be affected by th	nis	·
	facility's failure resul	lted in Resident #58 eloping 📑			deficient practice.		
	from the racinty, sua	staining an open tracture ("If such a way that bone			aoxidicine process.		
(fragments stick out	through the skin or a wound	<u>[</u>	ı	Measures/systematic change	e muí	1
	penetrates down to	the broken bone, the fracture	ŗ	٦.	in place to ensure that the	's bar	
:	ia called an "open" d	or compound fracture") in her				İ	}
;	nght aim requiring s	surgical repair, and abrasions or face, piccing Resident #58			deficient practice does not		
- 1	in immediate Jeopa	rdy (a situation in which the			reoccur:		
	providers noncompl	liance with one or more ticlpation has caused, or is			The facility staff were in-ser	rviced	-
	likely to cause serior	us injury, harm, impairment,			by the facility DON /		
1	or death to a resider	nt).			Administrator on the follow	ing on	
}	Maria de la compania				2/17/17 through 2/20/17 du	- I	ĺ
	The Youth Toppard	VHA) was informed of the y on 3/1/17 at 1:25 PM in her			-	.1116	1
	office.	On Still at 1.25 Pill In her			face to face training/lecture		ŀ
1					sessions (and for those not		.]
	F-323 resulted in Su	ibstandard Quality of Care.			attending either of these ses	1	
	The findings include	.ı,			they were in serviced in the	Same	
l	THE THEMES	u .			manner before their next		ļ
	Review of the facility	's policy "Wandering and			scheduled shift)		1.
1	Elopement," revised	8/4/03, revealed " Purpose:		i.	Dementia: types of dementi	a,	ſ
ł	To provide specific g	pridelines regarding te of the resident with the			causes and behavioral symp	toms	1
1	accessment App Car ander since the bildering	e of the resident with the and/or etopeThe facility will		ii.	Wandering behaviors and		{
	provide preventative	interventions as necessary			identification of resident sp	ecific [}
1	for the safety of the r	esidentIf the resident is			"triggers" for wandering an		1
	identified as being at	trisk for elopement, the			clopement behaviors	-	[
l	resident will be place	ed on q 15 minute [every 15		;::		,	Í
	manasal vishal won	toringThe q 15 minute		iii. 	Exoperion risk factors	,	i

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STATEMEN	T ÓF DEFICIENCIES OF CORRECTION	(X.1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	. <u>0930-039</u> 1 F SURVEY MPI ETEN
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NAME OF	PROVIDER OR SUPPLIER		<u> </u>	\$()	REET ADDRESS, CITY, STATE, ZIP CODE	1 <u></u> -73/	02/2017
CAMBR	DGE HOUSE, THE			250	0 BELLEBROOK RD RISTOL, TN 37620		
(XA) KO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BIS PRECEDED BY FULL SC (DENTIFYING INFORMATION)	IO PREFI TAG	ıx Î	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION BLIO CHOSS-REPERENCED TO THE APPR DEFICIENCY)	O N AIF	COMPLETION COMPLETION
F 323	Visual monitoring will Wandering Resident for continuous of resident for continuous documented white of facility will ensure and door alarms or sense 24 hours a dayThe each door alarm of salarm Maintenance problem noted with post a staff member alarm is functional only resident attempthe charge nurse as discovered missing to the facility, the change nurse as discovered missing to the facility, the change nurse as discovered missing to the facility, the change nurse as discovered missing to the facility the facility including Dysphagia ability severe enouge activities of daily into Osteoporosis and December 1.	Il be recorded on the at Monitor toolRe-evaluation nummy q-15 minute checks will urs. Decision of IDT am] and Physician will be a to continue or discontinue demonstrated and or q-15 minute checksThe my monitoring devices such as or bracelets are operational at misc/designee will check hilt and record on 'Door Checklist'If there is a the duor alarm, the facility will at the exit door until door All personnel are to report ting to leave the premises to soon as possibleResident from the facilityUpon return arge nurse interventions to prevent we revealed Resident #58 was by on 6/13/13 will diagnoses. Demontia (a loss of mental to interfere with normal mg). Hypertension.	F	V	iv. Wandering risk assessme completed on admission quarterly and with any schange in condition. v. Monitoring functionality wanderguard system: vi. Each resident's wanderguard schecked for functionality daily by Maintenance Director or designee and on weekenday shift supervisor. viii. Developing and implement effective interdisciplinar care for the resident at riwandering / elopement ix. The Cambridge House's and procedure for Wand Elopement/ Managing Eincluding how to respond door alarm or missing rex. For the Resident observe attempting to leave the premises to the charge mission as possible.	y of the guard netionalit ted on the is tested y the r his ds by the enting an ry plan of sk for policy ering and lopement d to a sident: ed remises: rt any ave the	y

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM.	03/16/2017 APPROVED 0936-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROMDERISUPPLISMEI IA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. FILITOING		DISTRUCTION .	(X3) DATE SURVEY COMPLETED	
		445190	n, wing		the state of the s	03/0	02/2017
NAME OF I	ROVIDEN DIK SUPPLIER			TRF	FTADDRESS, UTY, STATE, ZIP CODE		······································
CAMBRI	DGF HOUSE, THE		1		ELLEBROOK RD TOL, TN 37620		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENY OF DEFICIENCES MUST BE PREGEDED BY PULL SO IDEN BEYING INFORMATION	in PREFIX TAG		FROVIDER'S PLAN OF COLUMN (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY))BE - 1	(XS) COMPLLITION DATE
	Continued From pa Review of a facility dated 2/23/16 revea from the facility at 2 tourd outside the fa door. Continued re revealed "door al out the 500 half doo hulfding, brought ba Aesistant [CNA] #2; Resident with "no Level of conscious with confusion" Review of the care and elopement, rev interventions in play were implemented. Review of a visual e ntaff charted every of Resident #58 for on 2/23/16. Review of the Want Assessment dated #58 was essessed elopement risk. Review of a facility dated 3/16/16 revea from the facility at 8 found outside the fr Continued review of "resident went out		F 328	a. b. c. d. e. a. b.		y and c a nd use action rain dent. nee to inger, lized. r staff er to the s. ne uries. Refer ement an)	
	fand) brought back	into building" Resident with tries noted. I level of	ļ	d. e.	Notify the resident's respons	sible	
GUBA CAN' 116	" , alert/confused"		<u> </u>		party/legal representative of incident.	me	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					03/16/2017	
		& MEDICAID SERVICES	·				APPROVED 0938-0391	
STATEMENT AND PLAN C	OF DEFICIENCIES PECONINECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MIJI TIPLE CONSTRUCTION A. RUILDING			(X3) DA3	(X3) DATE SURVEY COMPLETED	
		445180	n wing			034	02/2017	
" NAME OF I	ROVIDER OR SUPPLIER			ST	TREET ADQHESS, CITY, STATE, ZIP	CODE	<u>02120 1</u>	
CAMBRI	DGE HOUSE, THE				60 DELLEBROOK RD IRISTOL, IN 37620			
(X4) ID PREFIX TAG	(EAGN DEFICIENCY	TEMENT OF PETICIFINE ES MUST DE PRECEDED BY PULL SCIDENTIFYING BEFURMATION)	אנין רתנדךן מו		PROVIDER'S PLAN OF GO (EACH CORRECTIVE ACTION CROSS-REPERENCED TO THE DEF(CIENCY)	N €HOULD B≓	CONCLETION CONCLETION	
F 323	Continued From pa	ge 23 plan dated 3/16/16 revealed	Fa	323	f. Complete and file at report. g. Make appropriate no			
	"cont [continue] abr interventions were i	we interventions" and no new mplemented.		ľ	resident's medical re update the resident's to include elopemen	cord and plan of care	,	
ह ³	staff charted every	observation form revealed tho 15 minute visual observations 72 hours after her clopoment			h. Document the incide hour report.	ent on the 24-		
!	4/25/16 revealed a l	orly MDS assessment duted Briof Interview for Mental adicating the resident had a pairment.	; ;		xi. For the Resident disc missing from the fac 1. All personnel are to resident suspected of	ility. report any		
. , ;	Review of Wanderlr Assessment review Resident #68 with ", wendering noted"	ig and Flopement dated 4/26/16 revealed ,.no further episodes of			missing to the charge soon as possible. 2. If an employee disco resident is missing fr	e nurse as	,	
. :	dated 5/10/16 revea from the facility at 4: found outside the fa	ncident/Accident Report iled Resident #58 had cloped 10 PM. Resident #58 was cility by the 500 hallway exit			facility, he/she shoul a. Determine if the resident an authorized leave of	d: dent is out on		
	revealed "residen 500 hall rolling down with "no apparent	iew of the accident report I observed by CNA outside I the sidewalk" Resident" Injuries noted. Level of marked as "alert with			not; b. Notify the charge nui immediately. He/sho direct a search of the	will then building(s)		
,	Review of the care pand elopement, data (continue) above interiors were in	plan problem area wandering of 5/10/16 revealed "contemporalions" and no new uplemented.		3	and premises including of the building. If no 3. The charge nurse will search of the facility using the "Search Gri	ng all areas of located; I direct a grounds		
	staff charted every 1	bsorvation form revealed the 5 minute visual observations 72 hours ofter her elopement			Elopement" – facility indoors and outdoors facility.	specific for		

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	JF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		T CONSTRUCTION		E BURVEY PLETED
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CAMBRI	DGE HOUSE, THE	•		M RELLEGROOK RD RISTOL, TN 37620		
(X/I) ID .	SUMMARY STA	TEMONT OF DEFICIENCIES	r ip	PROVIDER'S PLAN OF CORRECT	rion	(MN)
PREFIX		YMUST REPRECEDED BY FULL SCIDENTIFYING INFORMATION)	PAEFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS REI-GRENCED TO THE APPR DEFICIENCY)	ULU BË	OAIS CUMATELION (XV)
F 323	Gontinued From pa on 5/10/16.	ye 24	F 323	 The charge nurse will tal resident headcount. 	ce a	
	Review of the annu 12/14/16 revealed	al MDS assessment dated a Brief Interview for Mental adicating the resident had a	; ,	5. Notify the administrator a director of nursing as soo	n as	
	severe cognitive Im		ŀ.	possible and within 30 m 6. The Director of Nursing,	inutes.	
	at 6:00 PM "caug outside door next to brought resident ba room 509" Review of a nurse's at 8:15 PM, "I say	s note dated 1/17/17 revoaled: pht resident bying to open that roomat 8:30 PM CNA lekfrom around door at note dated 1/17/17 revealed ([Resident #58] about 8:15 b out that doorfollowed me	ļ.	designce, will coordinate following scarch procedu a. Divide the local area arou facility and assign a staff to search each area and rothe coordinator when the complete.	the re; ind the person eport to	
	down the 500 hall v Review of a facility dated 1/17/17 rever from the facility at 9 found outside the 4 accident report rever CNA's + [and] hosp lying outside, at bot [wheelchair] beside Continued review re were "abraislon/s	ranting to go out that door" Incident/Accident Report aled Resident #58 had eloped a:00 PM. Resident #58 was 00 hollway exit. Review of the ealed "catled to eastwing by itality aide, found resident from of 400 exit hall ramp w/c her) on stomach" evealed injuries sustained skin tear nose, wrist swollen"		 b. Determine the areas/sites community with which the resident may have familia (stores, restaurants, or hor Assign necessary staff to these areas. 7. If the resident is not locate within one hour, notificate should include, but is not to: 	e rity, ne). search ed on	
	"confused". Emerg called and transpor hospital for admissi Review of the hosp history & (and) phys "the patient is cor by her daughterto door in her wheelch	s masked as "alort" and ency Medical Services were ted Resident #58 to the en. ital Emergency Department sical, dated 1/17/17, revealed fused and history is provided hight the patient went out the ear, slid down a sidewalk wer and tried to outch herself	. c	to: a. Responsible Party b. Resident's physician c. Local police d. Hospitals, emergency roos d. Upon return to the facility charge nurse should: Examine the resident for i	, the	

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AND M AN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE/FUELA IDENTIFICATION NUMBER:	A. SUITEDIM	PLE C	ONSTRUCTION	(X3) DAT	E SURVEY
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l CAMBRU	DGE HOUSE, THE				BELLEBROOK RD		
VA	DOE NOODE, THE		ļ	BRIS	STOL, TN 37620		
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	ambulatory in 3 yeathe patient has signand open right wrist and open right wrist Review of the hospidated 1/24/17, reversally and ulner fragreduction/ external distal radius fractumed local-loss anemia. Medical record review returned to the facility Review of a Wander Assessment dated 1/58 to be assessed elopement risk. Keylew of a visual of staff charted every of Resident #58 for the hospital on 1/24. Review of the care perisodes of wander above interventions' were implemented.	stateshas not been and is wheelchair bound prificant bruising to her face fracture" tal discharge Summaries, aled "open right distal cture, S/P (status post) open fixator application of right on 1/18/17Acute ew revealed Resident #58 by on 1/24/17. hing and Elopement Risk 1/24/17 revealed Resident as a wandering and bservation form revealed the 15 minute visual observation 1/2 hours after her return from 1/17. blan revealed "1/17/17 ng" and "cont (continue) and no new interventions	F 323	c. d. c.	Implement interventions to prevent further elopement. to the "Wandering and Flog Development of the Care P Notify the search team menthe administrator and the diof nursing that the resident been returned to the facility Notify the resident's attend physician of the incident. Notify the resident's responsarty/legal representative of incident. Complete and file an incide report. Make appropriate notations resident's medical record an update the resident's care play with elopement precautions. Document the incident on the hour report. The Administrator/designee ensure a completed report is forwarded to Risk Managemand all required state reporting the construction of the construction of the completed report is forwarded to Risk Managemand all required state reporting the construction of the completed report is forwarded to Risk Managemand all required state reporting the constructions.	(Reference) lan") nbers, irector has ing nsible othe in the in the lan will	
	AM, revealed the recusing her leat and le wheelchair around to	sident in her wheelchall, iff hand to move the le facility.			All employees were tested or	n	
1	12:00 PM per teloph	ospilality Ald on 2/16/17 at one, confirmed she found a, on the ground at the 400		1	their retention of the informa presented at these in-service sessions by March 2, 2017	tion	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN (H-ICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION			(XX) DATE SURVEY COMPLETED	
		445190	R, WINC				03/02/2017	
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				ſ	50 BELLEBROOK RD			
CAMERI	DGE HOUSE, THE				BRISTOL, IN 37620			
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	Continued From partial Hall door, at the on 1/17/17 at 9:00 by ground from another Observation of Res PM, revealed the result of the sure of the partial of the sure of the partial of the	ge 28 bottom of a concrete ramp PM after seeing her on the ar resident's room window. Ident #58 on 2/16/17 at 1;30 beident was in her whoelchair, left hand to move the the facility. Insed Practical Nurse (LPN) #1 PM in the conference room, ware Resident #58 was an ind attempted three times to the 8:00 PM, prior to her uliding on 1/17/17 at 9:00 PM, wrevealed there was not be evening of 1/17/17 to provide the resident #58 dkt not leave to confirmed the resident had the was going to try and elope", saviors exhibited by Resident might elope were increased theelchair and going to the exit putside. Resident #58 would every time but would look contirmed staff did not provide ent Resident#58 from eloping. #1 on 2/16/17 at 9:00 PM in the confirmed Resident #58 mont risk and had attempted at 8:00 PM, 8:15 PM, and		323	employee did not score 80%	on the new to the one of the one	e	
	9:00 PM. Continue not enough staff or provide supervision leaving the building	7 prior to her elopement at id interview revenied there was the evening 1/17/17 to to prevent Resident #58 from Continued interview at had a "noticeable chango in	j		assessment is completed on all residents upon admission, quarterly and with a significant change.			

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STATEMENT	FOR DEFICIENCIES OF CONNECTION	& MEDICAID SERVICES [X1) PROVIDER/SLIPPLIER/CUA IDENTIFICATION NUMBER:		Lu construction	ON HWO	ie sau∧e. i_gasa-òsa∏
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ļ	her behavior and de to try and elope". The sident #58 were wheelchair and goin looking outside. Reexit seek every time exit seek every time interview with the Adesident #58 exited dead battery. Observation of the Adesident #58 exited dead battery. Observation of the Adesident #58 exited dead battery. Observation of the Adesident #58 exited dead battery. Interview with the Factory in the Adesident #58 exited dead battery. Interview with the Factory in the Adesident #58 exited dead battery in the Adesident i	emeanor when she was going the behaviors exhibited by increased wandering in her ag to the exit doors and sident #58 would not try to but would look outside. Iminiatrator on 2/16/17 at Hall Exit door, confirmed the ound on 1/17/17, when the building, because it had a 100 Exit Hall door on 2/16/17 if a concrete ramp at long, leading from the door with a metal railing at the lond on one side. Imily Nurse Practitioner, the conference id not remember their about Resident #58's 16, 3/16/16 and 6/10/16, revealed that when someone lents as Resident #58, they cure unit for the resident to	F 323	The wandering and cloneme	ent he l ide s s; ent and and	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDE INSURING HIS ROUNDERS.		E CONSTRUCTION	OMB.NO. 0938-039- (X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER DGE HOUSE, THE	445190	2	TREET ADORESS, CHY, STATE, ZIP CODE 50 BBILLEBROOK RD (RISTOL, TN :37620	03	<u>/02/2</u> 017
(X4) (D PREFIX TAG	(EAGH DEFICIENCY	TEMENT OF DELICIENCIES MUST RE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PRGFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RF	(23) COMPLETION LIATE
	The Immodiate Jao 1/17/17 through 3/1 of Compliance, which like jeopardy, was rewere validated through solution, and stronsite on 3/2/17. The allegation of compliance of "Notice residents out of the notification), and properties and income egree C. 400 Hall fire oxide. Sun room egree C. 400 Hall fire oxide. 300 Hall fire o	pardy was effective from /17. An Acceptable Allegation ch removed the immodiacy of pectived and corrective actions ugh review of documents, all interviews conducted the surveyor verified the ence by: nain entrance egress doors the to Visitors" (not to let facility without staff per functioning of em on the following doors: ence room fire exit door door door door foor door stading entrance door (1) a 15 seconds delayed dimplemented after the /17; (2) a wanderguard alarm with a wanderguard bracelet doors lock, alarms sound, open until the resident with removed from the door area, acclet system was installed /17. Observation of and #68 on 3/2/17 at 2:00 If to have their wander guard these three residents were	<u> </u> 	band with the resident's name facility address and phone measured in the resident was completed on February 19, 2. The resident will be wear a wanderguard sensor. Complete on February 21, 2017. The resident's care plan will updated with interventions to minimize the resident's wandering/elopement behaving identified wandering patterns triggers. Completed on Marc. 2017. The Interdisciplinary team instituted a detailed plan of as indicated for residents who assessed to have a high risk elopement or other unshelysion.	placed ng this 19, ne ne, ne nor, tod be or; tor h 1, has care	

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED FORM	: 03/15/2017 LAPPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEWOUN (DENTIFICATION NUMBER		LE GUNSTRUGINON	<u>OM 6MO</u> rad (cX)	, <u>(1938</u> -0991 TE SURVEY APLE LEG
NAME OF PROVIDER OR SUPPLIER	446190		TREET ADDRESS, CITY, STATE, ZIP (O3.	02/2017
CAMBRIDGE HOUSE, THE			50 BLU,EUROOK HD PRISTOL, TN 37620		
PREFIX (FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY (ULL SC IDENTIFYING INFORMATION)	PREFIX JAG	PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OFFICIENCY)	1 \$1000 D.BE	(XS) COMPLETION DATE
and Egrens doors wandible alarm until the specific alarm and respecific alarm and respecific alarm and respecific alarmed doors when 3/2/17 between 1:8/4. Interviewed 6 vin AM and 12:00 PM respectively sign out a respectively. Unsafer the sign of the sintervity of the sign of the sign of the sign of the sign of the s	ralarms placed on the Fire will continuously emil an the staff respond to the manually deactivate it. taff response to all the manually deactivate it. 5 PM and 1-25 PM sisters on 3/2/16 between 8:00 regarding their knowledge idents out of the building enursing staff first, and how to resident from the facility. scallity's in-service records to reality in in-serviced on the exit doors and the following resident was in-serviced on the exit doors and the following rement Resident views beginning on 3/2/17 at to include the Administrator, 8 Director of Nursing, 6 Jurses, 20 Certified Nursing keeping and Laundry staff, 4 record staff, 1 Maintenance of Office staff, 2 Rehab staff, 1 tal of 50 employees. This is a level of comprehension ervice education regarding the ringes to the Wandoring and and implementation of the insafe Resident.	F 323	F323 cont (See attaches	inued pages)	March 24, 2017

<u>CENTEI</u>	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 03/15/2017 AAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA). 0938-0391 TC SURVEY MPLETED
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NAME OF I	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03.	/02/2017
CAMBRI	DGE HOUSE, THE			250 BELLEBROOK RD BRISTOL, TN 37620		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	2. All audible door and Egress doors wand Egress doors wandible alarm until to specific alarm and rown and control of the specific alarm and rown alarmed doors when 3/2/17 between 1:05 4. Interviewed 6 vin AM and 12:00 PM mabout not letting reswithout notifying the properly sign out a rown alarm system on the policies: Wandering and Elop Wandering, Unsafe 6. Conducted interpolicies: Wandering and Elop Wandering, Unsafe 6. Conducted interpolicies: Wandering and Elop Wandering, Unsafe 7. Reviewed the facility's policies and Practical Nurses, Licensed Practical Nasistants, 3 House Dietary, 2 Medical Robrector, 2 Business Receptionist for a town was to determine the gained through in-sefacility's policies, challed the policy, arpolicy Wandering, Union Wanderin	alarms placed on the Fire vill continuously emit an the staff respond to the manually deactivate it. It aff response to all the antiggered by the surveyor on 5 PM and 1:25 PM. Sitors on 3/2/16 between 8:00 egarding their knowledge idents out of the building nursing staff first, and how to esident from the facility. It could be a continuously staff was in-serviced on the exit doors and the following to include the Administrator, 8 Director of Nursing, 6 lurses, 20 Certified Nursing keeping and Laundry staff, 4 ecord staff, 1 Maintenance Office staff 2 Rehab staff, 1 tat of 50 employees. This is level of comprehension exice education regarding the larges to the Wandering and and implementation of the insafe Resident.	F 323	9,	7. If a risk casily red on exil risk The ll be will fit as and fit as and ill be notes a shift on 1:1	

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PRLI IX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	×	(FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICE NOY)	DRE	COMPLETION DATE
E 373	Configured Faces				assessment had been comple	ted :	 -
1 37.0	Continued From pa	ge 29	F 33	23	according to facility policy b	T7]
	2. All audible door	alarms placed on the Fire			February 19, 2017. The Dire	y -4	
	and Egless doors w	vill continuously emit an			of Nursing and/or designs 1	ctol	
	specific alarm unur u	he staff respond to the nanually deactivate it.			of Nursing and/or designee l	เลร]
	opeome digitt ditq i	nendally deactivate it			ascertained that those resider		1 1
ŀ	3. Observed the s	taff response to all the			identified as at risk for clope	ment	
	alarmed doors wher	it frigaered by the surveyor on I			are wearing a wanderguard		
	3/2/17 between 1:08	5 PM and 1:25 PM.			sensor, that each resident's se	ensor	1
	4 Industrian - 1 A -			- L	is checked for functionality	everv	1
. [4. Interviewed 6 vi	silors on 3/2/16 between 8:00			shift and documented on the		
	about not letting rec	egarding their knowledge idents out of the building			medication administration re		
	without notifying the	nursing staff first, and how to			and that each alarmed exit d		1
	properly sign out a r	esident from the facility.		-	checked for functionality da		
		_					1 1
	Reviewed the fa	cility's in-service records to			the Maintenance Director an		} ·]
}	validate the facility s	taff was in-serviced on the			designee by February 21, 20	17,	!
	alarm system on the policies:	exit doors and the following			that the residents care plan h	เลร] [
ļ	Wandering and Elor				been updated to reflect their		
	Wandering, Unsafe	Perident		· • -	wandering triggers, complete	cdon	ļ <u>.</u>
	- tomasimg, empare	resident			March 1, 2017.		1
	6. Conducted inter	views beginning on 3/2/17 at		Į	The Director of Nursing or I	cr	1
1	12:44 PW With staff t	to include the Administrator, a l			designce will continue to		i I
ŀ	Registered Nurses,	Director of Nursing 8		-	complete an audit of 20% of	the	
	Licensed Practical N	lurses, 20 Certified Nursing			resident population to ascert	ານາ	1
	Assistants, 3 House.	keeping and Laundry staff, 4			that their wandering & clope	1177 EATT (] .]
Ī	Director 2 Business	ecord staff, 1 Maintenance		-	risk assessment has been	anem	1 1
	Recentionist for a to	Office staff 2 Rehab staff, 1 tal of 50 employees. This					·
	Was to determine the	e level of comprehension			completed according to facil	ıty]
	gained through in-se	rvice education regarding the		-	policy, that those residents	·	Į ļ
	racility's policies, cha	inges to the Wandering and			identified as at risk for elope	ment	
	Elopement policy, ar	implementation of the		}	are wearing a wanderguard		
	policy Wandering, U	nsafe Resident.			sensor, that each residents se		
					is checked for functionality		¦ ·
	Noncompliance cont	inues at a scope and severity			shift and documented on the	•	
	of "D" for monitoring	the effectiveness of			medication administration re	cord	
	7(02.99) Providus Marriss - 5	d evaluation of monitoring by			. and that each alarmed exit de]

DEPARTMEN	NT OF HEALTH	AND HUMAN SERVICES				PRINTF(D. 03/15/2017 MAPPROVED
STATEMENT OF D	EFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CHA (DENTIFICATION NUMBER.			CONSTRUCTION	OMB No	O. 0938-0394 NE SURVILY OMFIDENCE
		445190	D. WING				
CAMBRIDGE	DER OR SUPPLIER			250	REET ADDRESS, CITY, STATE, ZIP CODE 1 BELLEBROOK RD RISTOL, TN 37620		3 <u>/</u> 02/2017
(X4) ID PREFIX TAG	(L'ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FIND SC IDENTIFYING INFORMATION)	ID PREFI TAG	\neg	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
2. and aud spe 3. alar 3/2/4. AM abor with prop 5. valid alarm policing War 6. 12:4 Reg Lice Assi Diet Dire Reco was gain facili Elop polici	Egress doors where a larm until the control of the served the served the served for and 12:00 PM report not letting respond to the facility service was the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility service of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility o	alarms placed on the Fire vill continuously emit an the staff respond to the manually deactivate it. taff response to all the partiagered by the surveyor on 5 PM and 1:25 PM. sitors on 3/2/16 between 8:00 egarding their knowledge idents out of the building enursing staff first, and how to resident from the facility. acility's in-service records to staff was in-serviced on the exit doors and the following perment resident from the Administrator, 8 Director of Nursing, 6 lurses, 20 Certified Nursing keeping and Laundry staff, 4 ecord staff, 1 Maintenance of Office staff 2 Rehab staff, 1 tal of 50 employees. This is elevel of comprehension ervice education regarding the langes to the Wandering and and implementation of the insafe Resident.	F3		checked for functionality de the Maintenance Director of designee, that the residents plan has been updated to retheir wandering triggers and interventions implemented to mitigate those wandering triggers and it will be completed weekly for four weeks and to monthly for two months. The results of the audit will be presented to the QAPI common for their review and further recommendations. Date of Correction: March 2, 2017	r his care flect loo ggers. l hen nc	
corre	" for monitoring	tinues at a scope and severity the effectiveness of id evaluation of monitoring by					

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DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 03/15/2017
CHNIE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 0938-0391
NNU STAM U	OF DEFICIENCIES	(X1) PROVIDER/SUPPI IENCUA IDENTIFICATION NUMBER		LE CONSTRUCTION	(x3) DATE STRAND
		. 446190	R. WING	·	1
NAME OF	PROVIDER OR SUPPLIER	·	 	STREET ADDRESS, CITY, SYATE, ZIP CODE	03/02/2017
C A BOLLLI	ner House Suc			250 BEILEBROOK RD	
CANIDAL	DGC (IOUSE, THE			BRISTOL, TN 97620	
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F 323	facility is required to	ge 30 ce (QA) Committee. The submit a plan of correction. FFICIENT 24-HR NURSING	F 323		
\$\$=J	STAFF PER CARE 483.35 Nursing Scr	PLANS	F 363	F 353 Sufficient Staffing 24 hour Nursing Staff per Car Plans	'e
	The facility must har the appropriate comprovide nursing and resident safety and practicable physical well-heing of each mesident assessment and considering the diagnoses of the fact §483.70(e). [As linked to Facility be implemented bog (Phase 2)] (a) Sufficient Staff. (a)(1) The facility musufficient numbers of personnel on a 24 nursing care to all remaident care plans:	ve eufficient nursing stell with apetencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by		for those residents found to been affected by the alleged deficient practice: Resident # 58 was transferr the hospital post incident or January 17, 2017. Upon his return to the facility on January 24, 2017, a new wandering elopement assessment was completed and his/her care updated to identify the resid wandering/elopement trigge interventions to mitigate the triggers. The facility was in process of installing a wanderguard system at the terms.	have I cd to is/her lary and plan lent's ers and ose i the
	this section, licensed (ii) Other nursing per limited to nurse alde: (a)(2) Except when w this section, the facili	I nurses; and		of the incident and at this ting the court was dear. 1. Identify other residents who the potential to be affected same deficient practice and	me all shi as shawe by the
900 00/8 2000	(M Jaliu) Dinamana Davida - Co			corrective action taken	

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DEFICIENCY	PRÉFIX	EAGILATORY OR L	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SCIOLDITHYMG INFOHMATION	PRETIX	(EACH CORRECTIVE ACTION SHOULD	MAT	(XS) COMPLETION DATE
All residents have the potential to be affected by this deficient practice. (a)(3): The facility must ensure that illegreed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the pian of care. (a)(4) Providing care includes but is not limited to assessing, evaluating planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met an evidenced by: Based on review of the monthly staffing schedule, medical record review, observation, review of facility incident/Accident Reports and intriview the facility fielded to be adequately stafford to previote authorized for wandering and elopement right, of 2/a maletials riviewed. The facility is failure resulted in Resident riviewed. The facility is failure resulted in Resident riviewed. The facility is staffing an open tracture for the facility of failure resulted in Resident riviewed. The facility sustaining an open tracture for the provider's proper, placing right arm requiring surgical propar, placing right arm requirements of participation has caused, or is likely to cause sentious injury, harm, impairment, or death to a resident). The Administrator on the deficient practice does not reoccur: The facility staff were in-serviced by the facility DON / Administrator on the following on 2/17/17 through 2/20/17 during face to face training/lecture sessions (and for those not attending either	F 353	duty. (a)(3):The facility in nurses have the species necessary to demilled through redescribed in the plates of the providing car assessing, evaluating resident care plans needs. This REQUIREMENT by: Based on roview or schedule, medical review of facility incinterview the facility incinterview the facility staffed to provide a review elopement from the facility sughther bone broaks in fragments attack out panetrates down to is called an "open" or ight arm requiring a Resident #58 in immin which the provide more requirements is likely to cause set or death to a resident in the Administrator (If Inmediate Jeopard).	ivst ensure that licensed edific competencies and skill are for residents' needs, as eslient assessments, and in of care. Includes but is not limited to high planning and implementing and responding to resident's and responding to resident's and responding to resident's and responding to resident's and responding to resident's and responding to resident's and falled to be adequately upontision to prevent an fadility for 1 resident (#58) of differ wandering and is residents rewewed. The lited in Resident #58 eloping bailing an open frequer ("if such a way that bone through the skin or a wound the broken bone, the fracture or compound fracture") in her surgical repair, placing nediate Jeopardy (a situation is noncompliance with one or of participation has caused, or flous injury, harm, impairment, int).	ĭį	potential to be affected by deficient practice. 3. Measures/systematic changin place to ensure that the deficient practice does not reoccur: The facility staff were in-set by the facility DON / Administrator on the follow 2/17/17 through 2/20/17 duface to face training/lecture sessions (and for those not attending either of these sess they were in serviced in the manner before their next scheduled shift) i. Dementia: types of demonst causes and behavioral symmic wandering behaviors and identification of resident specification of	this ges put erviced wing on tring ssions same	

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		445100	B WING			03/(02/2017
NAME OF PROVIDER O	RSUPPLIER			TREET/	ADDRESS, CITY, STATE, ZIP CODE	1	<u> </u>
CAMBRIDGE HOUS	SE, THE				LEUROOK RO DL, TN 37620		
PREFIX (EAC)	H DEFICIENCY	ATEMENT OF DEMCIENCIES Y MUST BE PRECEORD BY FULL SC WENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH COMMECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE ((X3) COMPLETION DATE
Review of the event staffing of Licensed Nursing A on the event was admidiagnose of menta normal a Osteopor Review of problem: Resident Review of Assessminterview the resident Review of Assessminterview of	Ings Included Ings Included Ing/right so I Registed I Practical Assistants are not including shift would be including a shift a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid a solid	led; sary 2017 Staffing Schedule for shift (7 PM to 7AM) revealed ered Nurse (RN) supervisor, 2 Nurses (LPN), 5 Certified (CNA), and I Hospitality Aide		vii. viii. x	Monitoring functionality of wanderguard system: Each resident's wanderguard sensor is checked for functional sensor is checked for functional and documented MAR. L'ach alarmed exit door is to for functionality daily by the Maintenance Director or homeomore and on weekends day shift supervisor. Developing and implement effective interdisciplinary possesses for the resident at risk wandering / elopement. The Cambridge House's possesses for the resident at risk wandering / elopement. The Cambridge House's possesses for the Resident observed and procedure for Wandering Elopement/ Managing Elopincluding how to respond to door alarm or missing resident attempting to leave the president attempting to leave the president attempting to leave premises to the charge nurse soon as possible. If an employee observes a resident leaving the premise he/she should: Approach the resident calm walk with the resident. Harmally approach the resident.	ard tionality to the tested he is by the ting an plan of for olicy ing and pement to a dent: any e the se as es, aly and	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPL/ERIGIJA (DENTIFICATION NUMBER:		LC CONSTRUCTION	COMPULTED
		445190	D. WING		03/02/2017
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CAMBRI	DGE HOUSE, THE			250 BELLEBROOK RD	
771111			E	BRISTOL, IN 37620	
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-	Cognitive status wa "confused". Emerg celled and transport hospital for admissi Review of the hospital for admissi Review of the hospital for admissi Review of the hospital for admissi wheelchair, slid dow turned over and trie right armthe patic her face and open region face and open review of a nurse's at 8:00 PM, "caugoutside door next to brought resident baroom 509" Review of a nurse's at 8:16 PM, reveale half trying to go out the 500 half wanting interview with RN # the conference room member assigned to increased supervision the conference room member assigned to increased supervision I Resident #58". Interview with the Hid 12:00 PM per teleph Resident #58 outsident #58 outsi	s marked as "alert" and ency Medical Services were red Resident #58 to the on. tal Emergency Department fical, dated 1/17/17, revealed it went out the door in her on a sidewalk where she do to catch herself with her ent has significant bruising to light wrist fracture" note dated 1/17/17 revealed: the resident trying to open ther room at 8:30 PM CNA ck from around door at about 8:15 on T that door followed me down to go out that door" I on 2/16/17 at 11:45 AM, in a revealed there was no stall a resident #58 to provide an after the elepement of interview revealed "I was esidents", when asked if one had been implemented for espitality Aid on 2/16/17 at one, confirmed she found a on the ground on 1/17/17 at the one the ground on 1/17/17 at the one the ground on 1/17/17 at the one the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground on 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the on the ground of 1/17/17 at the one of the ground of 1/17/17 at the one of the ground of 1/17/17 at the one of the ground of 1/17/17 at the one of the ground of 1/17/17 at the one of the ground of 1/17/17 at the of 1/17/17 at the one of 1/17/17/17/17/1	F 353	side-by-side conversation verbal re-direction and disas you walk. b. Avoid confrontation and r from overpowering the research overpowering the research and is in imminent contact guidance may be a d. Obtain assistance from other members in the immediate vicinity, if necessary. c. Instruct another staff mentinform the charge nurse the resident has left the premisorm the charge nurse the resident has left the premisorm the resident for its charge nurse will: a. Examine the resident for its b. Implement interventions to prevent further elopement to the "Wandering and El Development of the Care e. Notify the resident's atterphysician of the incident. d. Notify the Director of Nu e. Notify the Director of Nu e. Notify the resident's respent party/legal representative incident. f. Complete and file an incident. g. Make appropriate notation resident's medical record.	efrain sident. stance to danger, utilized. her staff e nber to nat the ises. t, the injuries. to t. (Refer opement Plan) nding rsing. onsible of the dent us in the and
-	12:00 PM per teleph Resident #58 outsid 9:00 PM after seeing	one, confirmed she found a on the ground on 1/17/17 at a her on the ground from one window.	Fan	report. g. Make appropriate notatio resident's medical record update the resident's plan	ns in the

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Figure 1. (2001) Deficiency Must servised interphyticion (2002) Resplaced to the second of the building. Chair servised interphyticion (2002) PM, prior to her condinated interview revealed there was not enough staff on the evening of 1/17/17 at 9:00 PM. Continued interview revealed there was not enough staff on the evening of 1/17/17 to provide supervision to ensure Resident #58 did not leave the building. Chair and going to the exit doors and looking outside. Resident #58 would not ty to exit seek every time but did not provide increased supervision. Interview with CNA #1 on 2/16/17 at 9:00 PM in the conference room, confirmed interview revealed there was not eloping, they would redirect her but did not provide increased supervision. Interview with CNA #1 on 2/16/17 at 9:00 PM in the conference room, confirmed Resident #58 was a known elopement risk and had altempted three times to clope at 6:00 PM, 8:16 PM, and 8:30 PM on 1/17/17 por to her elopoment at 9:00 PM. Continued interview revealed there was not enough slaff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed there was not enough slaff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed there was not enough slaff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed there was not enough slaff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed there was not enough slaff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed there was not enough slaff on the evening the building. Continued interview revealed there was not enough slaff on the evening the building. Continued interview revealed there was not evening the building continued interview revealed there was not evening the building co		pachouse, me						
Interview with CNA #1 on 2/16/17 at 8:00 PM, and soperorder own, revealed she was aware Resident #58 was an otopopen, and interview revealed there was not enough staff on the event Resident #58 would not try to exit seek every time to provide anough enough for the resident has a not enough staff on the event Resident #58 fron leaving the building. Continued interview revealed there was not enough staff on the event Resident #58 would not try to exit seek every time but would look nutside. Continued interview revealed there was not enough staff on the event Resident #58 was a known elopement fask and had attempted three times to clope at 8:00 PM. Continued interview revealed there was not enough staff on the owing the building. Continued interview revealed there was not enough staff on the owing in the resident #58 would not try to exit seek every time but would look not start that a not enough staff on the owing in the resident #58 would not report. F 353 h. Document the incident on the 24-hour report. xi. For the Resident discovered missing from the facility, All personnel are to report any resident suspected of being missing to the charge nurse as soon as possible. 2. If an employee discovers that a resident is missing from the facility, he/she should: a. Determine if the resident is out on an authorized leave or pass. If not; b. Notify the charge nurse immediately. Ite/she will then direct a search of the building all areas of the building. If not located; 3. The charge nurse will direct a search of the building all areas of the building. If not located; 3. The charge nurse will direct a search of the soliding all areas of the building. If not located; 4. The charge nurse will direct a search of the facility grounds using the "Search Grid for Elopement" – lacility specific for indoors and outdoors of the facility. 4. The charge nurse will take a resident had a "noticeable change in her behavior and demeanor when she was going to by and elope". 5. Notify the administrator and director of mussing as	PREI'M	(EAGH DEFICIENCY	MUST REPRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE ATTION	H O BC	(NS) COMPLETION DATE
OREN CMG-9567 (09-98) Provious Vecsions Obstable Evolution 202711 Facility its Theorem		Interview with Licen on 2/16/17 at 8:50 F revealed she was a clopement risk and elope on 1/17/17 aff gotting out of the but Continued Interview enough staff on the supervision to ensure the building. She als a "noticeable chang demeanor when she the noticeable behard the noticeable behard wandering in her whore and looking or not try to exil seek e outside. Continued i provide supervision cloping, they would increased staff enough elopement three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope three times to clope the behavior and dealer behavior and dealer behavior and dealer to try and elope". The Resident #58 were in wheelchair and going looking outside. Resexit seek every time Continued interview in the continued interview.	sed Practical Nurse (LPN) #1 M In the conference room, ware Resident #58 was an had attempted three times to ter 8:00 PM, prior to her diding on 1/17/17 at 9:00 PM. revealed there was not evening of 1/17/17 to provide re Resident #58 did not leave to confirmed the resident had a in her behavior and a was going to try and elope". wiors exhibited by Resident might clopo were increased polichair and going to the exit utside. Resident #58 would very time but would look interview revealed staff did not to prevent Resident #58 from redirect her but did not upervision. If on 2/16/17 at 9:00 PM in a, confirmed Resident #58 nent risk and had attempted at 8:00 PM, 8:16 PM, and prior to her elopoment at interview revealed there was the evening 1/17/17 to continued interview t had a "noticeable change in neanor when she was going the behaviors exhibited by increased wandering in her to the exit doors and dident #58 would not try to but would look outside, revealed staff would redirect	F 353	a. b. 3.	to include clopement pred Document the incident on hour report. I'or the Resident discover missing from the facility. All personnel are to report resident suspected of being missing to the charge nursoon as possible. If an employee discovers resident is missing from the facility, he/she should: Determine if the resident an authorized leave or parnot; Notify the charge nurse immediately. He/she will direct a search of the building all of the building. If not located the building. If not located the facility grounsing the "Search Grid for Elopement" – facility special indoors and outdoors of facility. The charge nurse will the resident headcount. Notify the administrator	the 24- ed tany g se as that a he is out on ss. If then ding(s) I areas eated; ect a unds r cific for the ke a and on as	

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DEPART CENTER	MENT OF HEALTH	AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>				FORM	03/15/2017 APPROVED
STATEMEN)	ON DELICIENCIES	(X1) PROVIDENSION NUMBER:			соматкиструм	(X3) DATI	0938-0391 6 SURVEY PLETED
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F 353	increased supervisit people to bed". The Immediate Jeo 1/17/17 through 3/1 of Compliance, was removed the immediate for the control of the immediate of the immediate and correct through review of distail interviews consurveyor verified the surveyor verified the s	id not have staff to provide on as they were "busy putting pardy was effective from /17. An Acceptable Allegation of received on 3/2/17 which diacy of the Jeopardy, was attended accuments, observation, and ducted onsite on 3/2/17. The allegation of compliance by: alarms placed on the Fire will continuously emit an the staff respond to the manually deactivate it. Itaff response to all the manually deactivate it. Solities in-service records 2/17 to validate the facility staff the alarm system on the exit ving policies; perment	F:	363	 6. The Director of Nursing, designee, will coordinate following search procedure. a. Divide the local area arou facility and assign a staff to search each area and reach coordinator when the complete. b. Determine the areas/sites community with which the resident may have familia (stores, restaurants, or how Assign necessary staff to these areas. F353 Continue F353 Continue F353 Continue F353 Continue 	the re: nd the person port to search is in the e inty, ne).	Mark

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SIATEMENT	FOR DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLICATION NUMBER	(X2) MU A. BUILI			TRUCTION	OMB NO (X3) DAT	0938-039 E SURVEY APLETED
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F 353	Continued From pa		F;	353	7.	If the resident is not loca within one hour, notifica should include, but is not to: Responsible Party Resident's physician	ted tion	DALE
	1/1//17 through 3/1, of Compliance, was removed the immed received and correct through review of dostaff interviews concesurveyor verified the	pardy was effective from 177. An Acceptable Allegation received on 3/2/17 which liacy of the jeopardy, was tive actions were validated ocuments, observation, and ducted onsite on 3/2/17. The allegation of compliance by:	-			Local police Hospitals, emergency roc Upon return to the facilit charge nurse should: Examine the resident for, Implement interventions prevent further elopement to the "Wandering and E	y, the injuries. to it. (Refer lopement	r L
;	and Egress doors wadible alarm until the specific alarm and not consider the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of t	alarms placed on the Fire ill continuously emit an ne staff respond to the nanually deactivate it. aff response to all the triggered by the surveyor on PM and 1:25 PM.			d.	Development of the Care Notify the search team in the administrator and the of nursing that the resided been returned to the facil Notify the resident's attemphysician of the incident.	embers, director nt has ity, nding	
	trom 2/17/17 to 2/22 was in-serviced on to doors and the follow Wandering and Elop Wandering, Unsafe 4. Conducted inter	ement Resident views beginning on 3/2/17 at		15 15 15 15 15 15 15 15 15 15 15 15 15 1	ſ.	Notify the resident's resp party/legal representative incident. Complete and file an inci- report. Make appropriate notation resident's medical record	of the dent us in the and	
	Registered Nurses, I Licensed Practical N Assistants, 3 Housel Dietary, 2 Medical R	o include the Administrator, 8 Director of Nursing, 6 iurses, 20 Certified Nursing keeping and Laundry staff, 4 ecord staff, 1 Maintenance Office staff 2 Rehab staff, 1			h.	update the resident's car with elopement precauti Document the incident of hour report.	ons.	

DEPARTMENT OF HEALTH AND HUMAN SLRVICES PRINTED: 03/15/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING __ COMPLETED 445190 B. WING 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 BELLEBROOK RD CAMBRIDGE HOUSE, THE BRISTOL, TN 37620 SUMMARY STATEMENT OF DELICITIONS (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉLIX. (EACH CORRECTIVE ACTION SHOULD BE PRECIX REGULATORY OR LSC IDEN HI YING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) The Administrator/designee will F 353 Continued From page 35 F 353 Resident #58, but did not have staff to provide ensure a completed report is increased supervision as they were "busy putting forwarded to Risk Management people to bed". and all required state reporting agencies. The Immediate Jeopardy was effective from All employees were tested on 1/17/17 through 3/1/17. An Acceptable Allegation their retention of the information of Compliance, was received on 3/2/17 which presented at these in-service removed the immediacy of the jeopardy, was sessions by March 2, 2017. If an received and corrective actions were validated through review of documents, observation, and employee did not score 80% or staff interviews conducted onsite on 3/2/17. The higher they were retrained on the surveyor verified the allegation of compliance by: above information. This inservice is also included in the new 1. All audible door alarms placed on the Fire hire orientation process and and Egress doors will continuously emit an reviewed annually with all audible alarm until the staff respond to the employees. specific alarm and manually deactivate it. Elopement drills were hold on-2. Observed the staff response to all the alarmed doors when triggered by the surveyor on February 17, 2017 for the 7am to 3/2/17 between 1:05 PM and 1:25 PM. 7pm shift and on February 18. 2017 for the 7pm to 7am shift. An 3. Reviewed the facilities in-service records clopement drill will be held by the from 2/17/17 to 2/22/17 to validate the facility staff Administrator or his designee on was in-serviced on the alarm system on the exit doors and the following policies: each shift twice a year with an Wandering and Elopement assessment of the staff Wandering, Unsafe Resident performance and adherence to facility policy during the drill Conducted interviews beginning on 3/2/17 at presented to the QAPI committee 12:44 PM with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 for review and further

Licensed Practical Nurses, 20 Certified Nursing

Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1

recommendations

PRINTED: 03/15/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING _______ COMPLETED 445190 D WING NAME OF PROVIDER OR SUPPLIER 03/02/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE HOUSE, THE 250 BELLEBROOK RD BRISTOL, TN 37620 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFFRENCLI) TO THE APPROPRIATE (X4) ID ťΩ PREFIX (EACH DLI ICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) F 353 Continued From page 35 F 353 The DON ascertained that 100% Resident #58, but did not have staff to provide of current residents wandering increased supervision as they were "busy putting assessments were completed by people to bed". February 19, 2017. The DON will ascertain that the wandering assessment is completed on all The Immediate Jeopardy was effective from residents upon admission, 1/17/17 through 3/1/17. An Acceptable Allegation quarterly and with a significant of Compliance, was received on 3/2/17 which removed the immediacy of the jeopardy, was change. received and corrective actions were validated through review of documents, observation, and The wandering and elopement staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by; risk assessments for all current residents were reviewed by the DON and/or designee and all 1. All audible door alarms placed on the Fire and Egress doors will continuously emit an residents identified as an audible alarm until the staff respond to the elopement risk had their care specific alarm and manually deactivate it. plans revised by the interdisciplinary team to include Observed the staff response to all the alarmed doors when triggered by the surveyor on identification of the resident's 3/2/17 between 1:05 PM and 1:25 PM. wandering patterns or triggers; interventions to minimize the Reviewed the facilities in-service records resident's wandering/elopement from 2/17/17 to 2/22/17 to validate the facility staff behavior and interventions to was in-serviced on the alarm system on the exit doors and the following policies: mitigate their individual Wandering and Elopement elopement risk factors by March Wandering, Unsafe Resident 1, 2017. The wandering and elopement risk assessments for all 4. Conducted interviews beginning on 3/2/17 at 12:44 PM with staff to include the Administrator, 8 residents will continue to be Registered Nurses, Director of Nursing, 6 reviewed by a licensed nurse and Licensed Practical Nurses, 20 Certified Nursing all residents identified as an Assistants, 3 Housekeeping and Laundry staff, 4 elopement risk have their care Dietary, 2 Medical Record staff, 1 Maintenance plans revised by the Director, 2 Business Office staff 2 Rehab staff, 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2017 FORM APPROVED OMB NO. 0938-0391

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F 353	increased supervision people to bed". The Immediate Jed 1/17/17 through 3/1 of Compliance, was removed the imme received and correctived and corrective of a staff interviews consurveyor verified the sudible alarm until specific alarm and 2. Observed the salarmed doors whe 3/2/17 between 1:0 3. Reviewed the from 2/17/17 to 2/2 was in-serviced on doors and the follow Wandering and Elo Wandering, Unsafe 4. Conducted inter 12:44 PM with staff Registered Nurses, Licensed Practical Assistants, 3 House Dietary, 2 Medical I	did not have staff to provide ion as they were "busy putting pardy was effective from 1/17. An Acceptable Allegation is received on 3/2/17 which diacy of the jeopardy, was clive actions were validated ocuments, observation, and ducted onsite on 3/2/17. The e allegation of compliance by: I alarms placed on the Fire will continuously emit an the staff respond to the manually deactivate it. Itaff response to all the intriggered by the surveyor on 5 PM and 1:25 PM. Cacilities in-service records 2/17 to validate the facility staff the alarm system on the exit wing policies: perment	F 3	interdisciplinary tear identification of the wandering patterns of interventions to minima resident's wandering behavior; and interventigate their individe elopement risk factor. For residents identification wandering/elopement following protective taken: Photo identification win a private area of the stations and at the frowas completed on Fe 2017. The resident will wear band with the resident facility address and protective dearly marked. This completed on February 21, 2017 The resident will be wanderguard sensor, on February 21, 2017 The resident's care plupdated with interventionimize the resident	resident's or triggers; mize the delopement entions to hual rs. ed at risk for t the measures are will be placed the nursing out desk. This bruary 19, ar a name the number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017. The number was try 19, 2017.	

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		lid not have staff to provide	' '	123.3	identified wandering patterns of		
	Increased supervision	on as they were "busy putting			triggers. Completed on March		
	people to bed".	on the diet were body putting			2017.	1,	!
		:			The Interdisciplinary team	has	:
	The Immediate Jeo	pardy was effective from			instituted a detailed plan of	care	
	1/17/17 through 3/1	/17. An Acceptable Allegation			as indicated for residents who		
	of Compliance, was	received on 3/2/17 which			assessed to have a high risk		
	removed the miller	diacy of the jeopardy, was stive actions were validated		ĺ	_	safe	í I
	through review of de	ocuments, observation, and		l	behavior. The plan of		1 1
	staff interviews con-	ducted onsite on 3/2/17. The		ĺ	identifies triggers	for	1
	surveyor verified the	allegation of compliance by:	I				
İ	•				wandering/elopement behav		
	مملح ما مالله ينهم 4			- 1		ccii	
	and Egrees doors	alarms placed on the Fire vill continuously emit an		- 1	implemented to minimize the		1 1
	audible alarm until t	the staff respond to the		- 1	triggers as of March 1, 2017.]
	specific alarm and r	nanually deactivate it.			resident is actively exit seekin	_	i i
				ı	is displaying other high		1 1
	Observed the s	taff response to all the			behavior and cannot be ea	isily	
	alarmed doors when	n triggered by the surveyor on			redirected s/he will be placed	on) [
	3/2/17 between 1:0!	5 PM and 1:25 PM.		ļ	1:1 monitoring until the		l i
	2 Douglasses of the state				sceking or other high	risk	
	5. Reviewed the 18	acilities in-service records			behavior has abated.	The	
	Was in-serviced on t	2/17 to validate the facility staff the alarm system on the exit			Director of Nursing will		1 1
	doors and the follow	ring policies:			notified immediately and s/he		
	Wandering and Elop						.
	Wandering, Unsafe				~	the	l i
+	-	1			facility, assigning staff	to] [
	 Conducted inter 	views beginning on 3/2/17 at			complete the 1:1 monitoring		1
	12:44 PM with staff	to include the Administrator, 8			calling in additional staff		
	Registered Nurses,	Director of Nursing, 6			indicated. This monitoring	and	[
	Assistante 2 Universit	Nurses, 20 Certified Nursing			the resident's response will		}
\	Dietan, 2 Medical 5	keeping and Laundry staff, 4 Record staff, 1 Maintenance			documented in the nurse's r		1 1
1	Director 2 Rusiness	S Office staff 2 Rehab staff, 1				-	<u> </u>
<u> </u>		Chice dian 2 Nonau Stan, 1		_ }			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PI		03/15/2017 ABBROVED	
		& MEDICAID SERVICES	<u>O</u>					FORM APPROVED 4B NO 0938-0391	
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I IQ EMAN	ROVIDER OR SUPPLIER			ST	REE	TADDRESS, CITY, STATE, ZIP CODE:	<u> </u>	0202011	
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F 353	increased supervisi people to bed".	lid not have staff to provide on as they were "busy putting	F3	353	4.	by the charge nurse for each the resident is placed or monitoring. Monitoring of corrective acti ensure the deficient practice not reoccur:	on to		
	of Compliance, was removed the immed received and correct through review of distaff interviews consurveyor verified the surveyor ver	acilities in-service records 2/17 to validate the facility staff the alarm system on the exit ving policies: pement				The Director of Nursing and her designee has completed a 100% audit of the resident population to ascertain their wandering & elopement risk assessment had been comple according to facility policy by February 19, 2017. The Director Nursing and/or designee has the complete according to facility policy by February 19, 2017. The Director Nursing and/or designee has the complete according to facility policy by February 19, 2017.	eted by ector		

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			,	PRINTE	D: 03/15/2017
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	Resident #58, but d increased supervisi people to bed". The Immediate Jeon 1/17/17 through 3/1, of Compliance, was removed the immediate received and correct through review of dostaff interviews conditions surveyor verified the surveyor verified the surveyor design and figress doors when additional alarm and in 2. Observed the stalarmed doors when 3/2/17 between 1:05 3. Reviewed the fafrom 2/17/17 to 2/22 was in-serviced on the doors and the follow	pardy was effective from /17. An Acceptable Allegation received on 3/2/17 which liacy of the jeopardy, was tive actions were validated ocuments, observation, and flucted onsite on 3/2/17. The eallegation of compliance by: alarms placed on the Fire ill continuously emit an ne staff respond to the nanually deactivate it. aff response to all the a triggered by the surveyor on PM and 1:25 PM. cilities in-service records /17 to validate the facility staff he alarm system on the exit ing policies:	F3	353	ascertained that those resider identified as at risk for clope are wearing a wanderguard sensor, that each resident's s is checked for functionality of shift and documented on the medication administration reand that each alarmed exit dochecked for functionality dain the Maintenance Director and designee by February 21, 20 that the residents care plan is been updated to reflect their wandering triggers complete March 1, 2017. The Director of Nursing or hadesignee will continue to complete an audit of 20% of resident population to ascerta that their wandering & eloperisk assessment has been completed according to facility policy, that those residents identified as at risk for cloperare wearing a wanderguard	ment ensor every cord oor is ly by d/or 17, as ed on er the tin ment	
	12:44 PM with staff t Registered Nurses, I Licensed Practical N Assistants, 3 Housel Dietary, 2 Medical Re	Resident views beginning on 3/2/17 at to include the Administrator, 8 Director of Nursing, 6 turses, 20 Certified Nursing Reeping and Laundry staff, 4 ecord staff, 1 Maintenance Office staff 2 Rehab staff, 1			sensor, that each residents se is checked for functionality e shift and documented on the medication administration re- and that each alarmed exit do checked for functionality dai the Maintenance Director or	very cord or is ly by	

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F 353	Resident #58, but d increased supervisi people to bed".	id not have staff to provide on as they were "busy pulling	F:	353	designee, that the residents can plan has been updated to reflet their wandering triggers and interventions implemented to mitigate those wandering trig. This audit will be completed weekly for four weeks and the	gers.	
}	The immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, was received on 3/2/17 which removed the immediacy of the jeopardy, was received and corrective actions were validated through review of documents, observation, and staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by:				monthly for two months. The results of the audit will be presented to the QAPI committe for their review and further recommendations.		
	and Egress doors wandible alarm until the specific alarm and not considered the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure o	alarms placed on the Fire Ill continuously emit an ne staff respond to the nanually deactivate it.		5.	Date of Correction: March 24 2017	۸.	
 	alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:25 PM. 3. Reviewed the facilities in-service records from 2/17/17 to 2/22/17 to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident						
1	12:44 PN With staff to Registered Nurses, [Licensed Practical N Assistants, 3 Housek Dietary, 2 Medical Re	riews beginning on 3/2/17 at o include the Administrator, 8 Director of Nursing, 6 urses, 20 Certified Nursing teeping and Laundry staff, 4 ecord staff, 1 Maintenance Office staff 2 Rehab staff, 1					

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	Continued From par Receptionist for a law was to determine the gained through instability's policies, chellopement policy, it Wandering: Unsafe uneafa wandering robservation with no Nursing for stoff regulations at the Quality Assurant facility is required to Refer to F-323 "." 483.70(h)(1)(2) RECOMEDICAL DIRECTOMEDICAL ge 36 ptal of 50 employees. This in level of comprehension online aducation regarding this implementation of the policy. Resident, and making sure esidents are made 1:1 diffication of the Director of placement and supervision, altinues at a scope and severity of the effectiveness of and evaluation of monitoring by the effectiveness of a correction. The policy of CA) Committee. The possibility of correction. SPONSIBILITIES OF DR I designate a physician to rector, a resident care policies; and of medical care in the facility. It is not met as ovidenced	F	353	Corrective action(s) accomplishes residents found to have affected by the alleged deficie practice: Resident # 58 was transferred hospital post incident on Jan 2017. Upon his/her return to facility on January 24, 2017 wandering and elopement assessment was completed a bis/her care plan updated to the resident's wandering/clo	shed for been nt I to the nuary I's o the , a new and identify	7,	
	Agreement, review of facility incident/Accility incident/Accilithe medical director care after signing 4	the Medical Director of medical records, review of dent Reports, and Interview, failed to coordinate medical of 4 elopement reports for 1 residents reviewed for			triggers and interventions to those triggers The facility the process of installing a wanderguard system at the t the incident and at this time	mitigat was in ime of	

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F 50·1	reviewed. The facilitesident #58 sustants bono breaks in such stick out through the down to the broken "open" or compoun repair and placing placing if Jeopardy (a situation noncompliance with participation has conserious injury, harm resident). The Administrator (immediate Jeopard office. The findings include Medical record reviewed admitted on 8/13/13 Dysphagia, Dementatives admitted on the Medical Following Cancer, Osteoporos Review of the Medical Piractor Duevaluate resident caund shall advise the	pornant of 29 residents bornant of 29 residents lity's failure resulted in ining an open fracture ("if the h a way that bone fragments e skin or a wound penetrates bone, the fracture is called an diffecture") requiring surgical Resident #58 in Immediate on in which the provider's none or more requirements of used, or is likely to cause of Impairment, or death to a NHA) was informed of the youn 3/1/17 at 1:25 PM in her ed: But revealed Resident #58 was to the diagnoses included in (a loss of mental ability derive with normal activities attension, History of Breasil	F 501	doors are alarmed include countyard door. 2. Identify other residents whe potential to be affected by deficient practice and what action taken: All residents have to be affected by this deficient place to ensure that the deficient practice does not reoccur: The Medical Director was serviced by the facility Active downs in the facility Active oversight of Incidents/Accunusual events in the facilities include: 1) a thorough revisional devents in the facilities and Accident reports signing, 2) need to look for resident behavior and or staff practices to administration and assist in	the same the the same corrective the potential ent practice es put in cient sinding for eidents and ity to few of each t before trends in afficating aviors	Эт I
	revealed " Problem	#58's care plan dated 2/9/16, I/NeedProblem Onset; /andering and clopement //i ry] of wandering"	·	•		

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F 501	Continued From pa	gc 38 Incident/Accident Report	F 50	01		3/24/1
	dated 2/23/16 rever from the facility at 2 found outside the 5/1 the accident report is sounding, resident with a outside of the bull [Certified Nurse Ass #3]" - Continued re Director algored the lated 3/18/16 revea from the facility at 8; found outside the frozenting lot. found buck into building" the Medical Director Review of a facility is dated 5/10/16 revea from the facility is dated 5/10/16 revea from the facility at 4; found outside the 50 accident report revea CNA outside 600 has Continued review resigned the form on 8 elopement.	aled Resident #68 had eloped 16 PM. Resident #58 was 10 hallway door. Review of revealed "door alarm went out the 500 hall door to alding, brought back in by istant (CNA) #2] and[CNA view confirmed the Medical form 2/26/16. Incident/Accident Report led Resident #58 had eloped 45 PM. Resident #56 was not doors in the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. In the parking lot. I		developing and implement appropriate plan of correct. The facility Administrator Medical Director will cootened analysis of all Incidents/Accidents at the QAPI committee meeting ascertain that individual retrends and facility wide to been identified, root cause trend(s) identified and cormeasures implemented to root cause of the negative effectiveness of the correct actions taken will be analyfurther recommendations the committee as indicated.	etion. T, DON and ordinate a controlly to esident ends have e of the crective address the trend. The etive excel and made by	
	was found outside th the accident report ra by CNA's + [and] hos	om the facility at 9:00 PM. Resident #56 and outside the 400 hallway exit, Review of lent report revoaled "called to eastwing at 4 and hospitality aide, found resident side, at bottom of 400 exit hall ramp w/c		5. Date of Correction: March	J. A*t, ZVJ. /	

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\$ \$=J	at 11:00 AM in her of monitor the Medical the facility's Incident ongoing basis. The all Incident/Accident hy the Medical Dire. 3. Interview with the at 2:16 PM, in the at 2:16 PM, in the at 2:16 PM, in the at 3:16 PM, in the action of the facility has allow him to the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the action of the	office, confirmed she was to I Director reading and signing t/Accident Reports on an equipment of Accident Reports on an equipment of Accident Reports reviewed and signed clor. The Medical Director on 3/2/17 conference room, confirmed he fill his contractual agreement was to read all eports prior to signing them, to better coordinate modical the facility. If the effectiveness of the evaluation of monitoring by ce (QA) Committee. The submit a plan of correction. (I)(i)(ii)(h)(i) QAA BERS/MEET (S) Int and assurance. Initialing services; Intermediate the signee; Intermediate of the tacility's are members of the tacility's	F 50°	I' 520 QAA Committee — Members/Meet Quarterly/ All residents have the potent affected The QAPI committee was reclucated by the Administrate March 1, 2017 on Root Caus Analysis and that when defice practices are observed to immediately correct the action report to QA. Each deficient practice identified will be fol through the QAPI cycle of Pl Study Act. (PDSA Cycle) The QAPI committee, led by	or on sections and lowed an-Do-	
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-	administrator, owner individual in a leader (g)(2) The quality a committee must: (i) Meet at least qual coordinate and evaluation is sues we assessment and as necessary; and (ii) Develop and impaction to correct ideal (iii) Disclosure of information of such correct ideal (iii) Disclosure of information of such committee with section. (i) Sanctions. Good committee to identify deficioncies will not sanctions. This REQUIREMENTAL DISCLOSURE OF SUCH CONTROL (iii) Pased on medical information of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	er, a board member or other ership roto; and assurance afterly and as needed to luste activities such as lith respect to which quality surance activities are blement appropriate plans of entified quality deficiencies; formation. A State or the equire disclosure of the mittee except in so far as elated to the compliance of a the requirements of this faith altempts by the yeard correct quality be used as a basis for it is not met as evidenced ecord review, review of facility urance (QA) Committee failed ent of a plan to provide		Nursing Administrator Socia	irector, anager rs at a otential nd demal control (s, QAP) adits of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o	3/24/17

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in Resident #56 sustaining an open fracture ("If the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" or compound fracture") requiring surgical repair, and abrasions and contustons to her face, placing Resident #56 in Immediate Jeopardy (a situation in which the provider's noncomplisance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediata Jeopardy on 3/1/17 at 1:25 PM in her office. The findings included: Medical record review revealed Resident #56 was admitted on 6/13/13. Her diagnoses included Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of hally living), Hypertension, Ostooporosis and Depression. Review of Resident #58's care plan dated 2/8/16, revealed "Problem/NeedProblem Onset. 2/8/16At risk for wandering and clopement // [related to] hx [history] of wondering. Medical record review and review of facility incident/Accident reports revealed Regident #58 had been found outside the facility, after each clopement, the facility information of the resident with every 15 minute observations for 72 hours. The facility did not implement any new interventions or	

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	revise the resident's resident from elopin Medical record rovid assessments reveal Identified as having Medical record revise Incidentified as having Medical record revise Incidentified in exit the PM, 8:15 PM, and 8 outside of the building her wheelent sustained a her face and suffere wrist requiring surgic Interview with the Medical recording. Contidered that he was the constant wandering allopement from the interview with recident sustained and incomplete the CA COA meetings. Contidered that he was the constant wandering allopement from the interview with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices with recident surgices.	s corn plan to prevent the og again. Dow of the resident's MDS led the resident was not wondering behaviors. Dow and review of facility ports revealed the resident a building on 1/17/17 at 8:00 pm, and was found 19, lying on the ground with furned, at 9:00 pm. The abrasions and contusions to d an open fracture of her cal intervention. Director on 2/17/17 at the Medical Director was a committee and attended the nued interview revealed he cing informed about Resident at occurred on 2/23/16, The Medical Director naware of the resident's and multiple attempts at facility. Further interview	(± 1	520	DEFICIENCY			
] 1	n QA during the past	year was on 1/31/17. This 58 eloped from the facility						

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CAMBRIDGE HOUSE, THE			250 BELLEBROOK RD BRISTOL, TN 37620					
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		(X1) PROVIDERISURPLIERGIA	(K2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO	OMB NO. 0938 0301 (X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	03/02/2017				
CAMBRIDGE HOUSE, THE				250 BELLEBROOK RD BRISTOL, TN 37620					
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F 520.	the Quality Assuran	ce (QA) Committee. The submit a plan of correction.	F 52						
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